MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09727

Reg. Dist. No. U-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland

How long in hospital or institution? 37 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2233 Frederick Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I ✓

3.(a) FULL NAME: NATHAN LEONARD ADAMS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Grace O. Adams

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): 6/12/1894

8. AGE:

Years	Months	Days	If less than one day
52	4	14	...hrs. ...min.

9. Birthplace: Midfield, Mass.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: Louis Adams
13. Birthplace: Unknown

MOTHER
14. Maiden name: Katie Leonard
15. Birthplace: New Hampshire

16. Informant: Registrar's Office, Clin. Records
Address: Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/30/46 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: 3801 Frederick Rd. Balto., Md.

18. Funeral director: Harry H. Witzke

Address: Hollins & Gilmor Sts., Balto., Md.

19. 10/29/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 19 46, at 8:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 19 46, to October 26 19 46 and that I last saw him alive on October 26 19 46

Immediate cause of death	DURATION
Coronary occlusion - acute	Sudden
Due to: Heart disease - coronary arteriosclerosis - anginal syndrome - myocardial insufficiency	5 months plus
Other conditions: Hypertension, arterial	14 years

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ...Injured at work?

23. SIGNATURE: Robert M. Cullison
Robert M. Cullison, M.D. Clin. or Dir.

Address: Fort Howard, Maryland Date signed: 10/27/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09728 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland

How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Balto.

City or town: Parkton
(If outside city or town limits, write RURAL and give nearest town)

Street No. Parkton, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: SAW

3.(a) FULL NAME: WILLIAM C. ARCHER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nora Archer

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): 11-17-75

8. AGE: Years	Months	Days	If less than one day
70	10	29	..... hrs. ..... min.

9. Birthplace: Harford, Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: Roland Archer
13. Birthplace: Belair, Md.

MOTHER
14. Maiden name: Emma Magnus
15. Birthplace: Belair, Md.

16. Informant: Registrar's Officer, V. A.
Address: Fort Howard, Maryland

17. Burial, (Burial, cremation, or removal. Which?) Date thereof Oct. 19, 1946 (month) (day) (year)

Cemetery or ~~crematory~~: West Liberty.

Location: White Hall, Md. R.D.

18. Funeral director: J. Jacob Hartenstein

Address: New Freedom, Pa.

19. ..... 19..... (Date rec'd by registrar)

Dawson L. Farber
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16, 1946 at 1:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11, 1946, to Oct. 16, 1946 and that I last saw him alive on October 16, 1946

Immediate cause of death	DURATION
Bronchopneumonia and Uremia	5 Days Unknown
Due to Urinary Obstruction	1 Yr. plus
Due to Hyperplasia of prostate	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison M.D. or other

R. M. CULLISON, M.D. CLIN. DIRECTOR

Address: V. A. Ft. Howard, Md. Date signed 10-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Dr. Schoppert – 2301 Annapolis Rd

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

09729 P

CERTIFICATE OF DEATH

420

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 2825 Georgia Ave. Baltimore Highlands
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore Highland (If outside city or town limits, write RURAL and give nearest town)
Street No. 2825 Georgia Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Rudolph Aschenbach

3. (b) Social Security Number 212-05-8800

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	divorced

6.(b) Name of husband or wife: Margaret
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 5 - 1913

8. AGE: Years	Months	Days	If less than one day
33 4y	9	15	hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Foreman
11. Industry or business: Rustless Iron & Steel Co
FATHER 12. Name: Christian Aschenbach
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Rosa Gonnager
MOTHER 15. Birthplace: Germany
16. Informant: Henry Aschenbach
Address: 2825 Georgia Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 23 - 1946 (month) (day) (year)
Cemetery or crematory: Loraine Park Cemetery
Location: Wonder View Road
18. Funeral director: Williams Cook Inc.
Address: 1217 St. Paul Street
19. 10-21 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 20 - 1946, at 11:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1946, to Oct 20 1946
and that I last saw him alive on 1946

Immediate cause of death	DURATION
(a) Coronary Thrombosis	6 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Paul Schofield M. D. or other
Address: 301 Empire Date signed: 10/20/46

Evidence for the change of date of birth is shown on FILM No. I 08 DEC 12 1946

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

09730
Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
114 Riverside Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County ~~Balto~~ Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 114 Riverside Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Arthur D Ballentine

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Catherine nee Jenning
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) Dec. 25 1880 1879

8. AGE: Years 66 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Balto (Town, county, and state)
10. Usual occupation Store Keeper.
11. Industry or business Retired
FATHER 12. Name Alexander Ballentine
13. Birthplace Balto.
MOTHER 14. Maiden name Clarabelle Saunders
15. Birthplace Balto.
16. Informant Mrs. Catherine Ballentine (wife)
Address 114 Riverside Rd.
17. Burial. (Burial, cremation, or removal. Which?) Date thereof 10/5/46 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.
18. Funeral director John J Connelly
Address 418 Eastern Ave. Essex 21
19. Oct. 4, 1946 (Date rec'd by registrar) John J Connelly, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1946 at 9 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1946, to Oct. 2 1946 and that I last saw him alive on Oct. 2 1946.

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days.
Due to	
Due to	
Other conditions Arteriosclerosis; Hypertension Chronic Nephritis	5 yrs.

(Include pregnancy within 3 months of death)
Major findings of operations no
Date of op.
Autopsy results no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James F Oliver M.D.
M. D. or other
Address 7605 Eastern Ave. Date signed 10/3/46
Essex Station 24, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C9731

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days.

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1805 N. Montford Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Charles J. Barnes

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	separated

6.(b) Name of husband or wife: Marie Barnes

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): January 23, 1898

8. AGE:

Years	Months	Days	If less than one day
48	9	8	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: wood-caulker

11. Industry or business: shipyard

MOTHER / FATHER

12. Name: John A. Barnes

13. Birthplace: altimore, Md.

14. Maiden name: Harriet Granger

15. Birthplace: Baltimore, Md.

16. Informant: Hospital Records

Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 4/46 (month) (day) (year)

Cemetery or crematory: Maryland Mem

Location: Balto Co Md

18. Funeral director: Welsh Funeral Home

Address: 2008 College

19. 11/4 .46 (Date rec'd by registrar) F. W. Hedrick Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 19 46 at 10:10 a.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3 19 46, to October 31 19 46 and that I last saw him alive on October 31 19 46

Immediate cause of death	DURATION
Acute myocarditis, cause undetermined.	2 weeks.
Due to	
Due to	
Other conditions: Reactive depression	Indef.

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: no.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Isadore Tuerk

Isadore Tuerk, M.D.

Address: Catonsville 28, Md. M. D. or other

Date signed: 10/31/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

09732

Reg. Diat. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Lutherville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Lutherville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Seminary Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Roy Edward Barton
3.(b) Social Security Number 579-32-9662

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Beatrice
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Sept. 13, 1908

8. AGE: Years	Months	Days	If less than one day
38	0	24	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Chauffeur
11. Industry or business
FATHER 12. Name Edward Barton
FATHER 13. Birthplace Harford Co. Md.
MOTHER 14. Maiden name Matilda Ayers
MOTHER 15. Birthplace Baltimore Co. Md.
16. Informant Daisy E. Burke
Address 1216 - 25th St. N.E. Wash. D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 10 1946 (month) (day) (year)
Cemetery or crematory Mt. Zion
Location Long Green, Md.
16. Funeral director Wm. Chas. A. Stella
Address 1603 Druid Hill Ave.
19. 10-10-46 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1946 at 2.30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 1946 to Oct 7 1946
and that I last saw him alive on Oct 7 1946.

Immediate cause of death	DURATION
Congestive Heart failure (Acute)	3 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Bennett A. Glaser
M. D. or other
Address Lutherville, Date signed 10/7/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

C9733

Reg. Dist. No. 441

1. PLACE OF DEATH:
County Balto
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
952 Renfrew Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)
State Md County Balto
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 952 Renfrew Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary P Bedsworth

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife —
B.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Unknown 1866

8. AGE: Years 90 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace maryland (town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Ed. Crockett
13. Birthplace Md

MOTHER 14. Maiden name Unknown
15. Birthplace Md.

16. Informant —
Address —

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/8/46 (month) (day) (year)
Cemetery or crematory Texas Alms House
Location Texas Md.
18. Funeral director John G Connelly
Address 418 Eastern Ave.

19. 10/8 (Date rec'd by registrar) 1946 John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Heart Failure	
Malnutrition	
Senility	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M D Mund M. D. or other
Address Essex Date signed 8 Oct 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

2-25

2-440 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

09734

CERTIFICATE OF DEATH

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Baltimore

City or town Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Violet Bosley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Noah A. Bosley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 13 1859

8. AGE:

Years	Months	Days	If less than one day
87	4	28	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Nurse

11. Industry or business

FATHER

12. Name Noah A Bosley

13. Birthplace Maryland

MOTHER

14. Maiden name Josephine Stone

15. Birthplace Maryland

16. Informant Miss Edith Bosley

Address Owings Mills, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 13/46 (month) (day) (year)

Cemetery or crematory Wesley

Location Carroll Co Md

18. Funeral director Edw Clifton

Address Hampstead Md

19. Oct 11 1946 (Date rec'd by registrar) Mary B Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11/46 19..... at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-30 19..... to 10/11/46 19.....

and that I last saw h.er alive on 10/10/46 19.....

Immediate cause of death	DURATION
Uremic Coma	5 days
Due to Chronic nephritis	years
Due to arteriosclerosis	
Other conditions abdominal mass	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James G. Saffell M. D. or other

Address Reisterstown Md Date signed 10/15/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09735

CERTIFICATE OF DEATH

Reg. Diat. No. 381

1. PLACE OF DEATH:
County Balto
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 6702 Brighton Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6702 Brighton Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Columbus Z. Botzler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 16 1880

8. AGE: Years	Months	Days	If less than one day
66	3	15	..... hrs. ..... min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Columbus Z. Botzler
13. Birthplace Balto. Md.

MOTHER
14. Maiden name Cassandra A. Hurling
15. Birthplace Balto Md.

16. Informant Ellen C. Bladders
Address 6706 Brighton Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/2/46 (month) (day) (year)
Cemetery or ~~crematory~~ London Park
Location Balto. Md.

18. Funeral director William Cook Inc.
Address 1217 St. Paul St

19. 11/1 46 (Date rec'd by registrar) A. W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31st 1946 at 2:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946, to Oct 31 1946
and that I last saw h..im alive on Oct 27 1946

Immediate cause of death	DURATION
Chronic Gastro-Enteritis with probable Malignancy	4 mos
Due to	
Due to	
Other conditions Mentally retarded	always

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged ststistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. B. Cook M. D. or other
Address 7201 York Rd Date signed 10-31-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09736

CERTIFICATE OF DEATH

Reg. Diat. No. 310

1. PLACE OF DEATH:

County: Balto.

City or town: Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 5013 Gwynndale Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5013 Gwynndale Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: ANNA ANDERSON BOWEN

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Millard S. Bowen

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 13, 1871

8. AGE: Years	Months	Days	If less than one day
75	9	9	..... hrs. ..... min.

9. Birthplace: T. B., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Notley D. Anderson

13. Birthplace: Ky.

MOTHER — 14. Maiden name: Carrie V. Shipps

15. Birthplace: Va.

16. Informant: Mr. Morton W. Bowen

Address: 5002 Gwynndale Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/25/46 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 10/24 19 46 (Date rec'd by registrar) A. E. Herrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 22, 19 46 at 9:15A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 19 45 to Oct 22 19 46 and that I last saw h.. alive on Oct 22 19 46

Immediate cause of death	DURATION
Pulmonary Hemorrhage	
Due to	
Chronic Pulmonary TB.	7
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. A. Dooley M. D. or other

Address: 5 Medical Arts Bldg. Date signed: Oct 23 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-E)

CERTIFICATE OF DEATH

09737

Reg. Dist. No. 42

1. PLACE OF DEATH:
County Baltimore
City or town Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs
Hospital, institution, or street address where death occurred: 4504 Rehbaum ave
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4504 Rehbaum ave
(If rural, give LOCATION)
2.(a) If veteran, name war non

3. (a) FULL NAME (Henry Duncan Boyd, Jr.) Henry Duncan Boyd Jr

3. (b) Social Security Number ?

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) July 28, 1891

8. AGE: Years 55 Months 2 Days 28 If less than one day ... hrs. ... min.

9. Birthplace Baltimore City
(Town, county, and state)
10. Usual occupation Clerk & Secretary
11. Industry or business B. & O. R.R.

FATHER
12. Name Henry Duncan Boyd
13. Birthplace Liverpool Eng.

MOTHER
14. Maiden name Mary Elizabeth Kolb
15. Birthplace Baltimore Md

16. Informant Mrs. Esther Muryl[illegible] Fletcher
Address 4504 Rehbaum Ave. Halethorpe, Md.

17. Burial Date thereof 10-29-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18. Funeral director HENRY SANDER & SONS, INC.
Address NORTH AVE. & BROADWAY

19. 10/28 46 A. W. Hedrick
(Date rec'd by registrar) Dr. Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1946, at 1:45 [illegible] M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1946, to Oct 25 1946
and that I last saw him alive on Oct 25 1946

	DURATION
Immediate cause of death Cirrhosis of liver	4 mo
Due to Myocarditis with decompensation	4 mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur?
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address 5709 Main st Elkridge Date signed [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

09738 Y

Reg. Dist. No. 3 8 +

1. PLACE OF DEATH:
County: Baltimore County
City or town: Brooklandville MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Brooklandville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Old Court Road
(If rural, give LOCATION)
2.(a) If veteran, name war: NO

3. (a) FULL NAME: Mary LeClair Brady

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: James H. Brady
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): May 14 1884

8. AGE: Years: 62 | Months: 5 | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Baltimore MD.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: James Bosley
13. Birthplace: Baltimore County

MOTHER
14. Maiden name: LeClair Waters
15. Birthplace: Baltimore County

16. Informant: Ruth W. May
Address: Hunts Lane. Lutherville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 17 1946 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: London Park

18. Funeral director: M. Cook Inc
Address: 1719 St Paul St

19. 10/16 46 A.W. Hedrick M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 15 1946, at 9 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1946, to Oct 15 1946
and that I last saw her alive on Oct 14 1946

Immediate cause of death	DURATION
arterio-sclerosis	
hypertension	15 yrs.
Due to	
Due to	
Other conditions: Cardio-Vascular renal disease.	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Palmer F. C. Williams. Palmer F. C. Williams M. D. or other
Address: Pikesville Md. Date signed: 10/15/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of cemetery shown on Film G109 4/24/47 dm Wife's Statement.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09739 44
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland
How long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Belair
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rt. # 4
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-2

3.(a) FULL NAME: TROY BROWN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Melba Brown
6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): 2-23-1916

8. AGE: Years	Months	Days	If less than one day
30	8	0	hrs. min.

9. Birthplace: Cumberland, Kentucky
(Town, county, and state)
10. Usual occupation: Millhand
11. Industry or business

FATHER
12. Name: James Brown
13. Birthplace: Cumberland, Ky.

MOTHER
14. Maiden name: May Eldridge
15. Birthplace: Cumberland, Ky.

16. Informant: Registrar's Office, Clin. Records.
Address: Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal) Which? Date thereof 10-25-46 (month) (day) (year)
Cemetery or crematory: Cumberland Kentucky
Location: Cumberland, Kentucky
18. Funeral director: Oder Funeral Home Inc
Address: 4644 York Road,

19. 10/24 1946 A. H. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23, 1946 at 8:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15, 1946 to October 23, 1946 and that I last saw him alive on October 23, 1946

Immediate cause of death	DURATION
VIRUS PNEUMONIA	2 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: Substantiated Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles Collier M.D. M.O.D. M. D. or other
Address: V.A. Fort Howard, Md. Date signed: 23 Oct 46

10459

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(186a ★

CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 4 months, 10 days
Hospital, institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 1 year, 4 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 607 Otsego St.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: George Carman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	widowed

6.(b) Name of husband or wife: Mary C. Standiford
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): March 3, 1871

8. AGE: Years	Months	Days	If less than one day
75	7	15	....hrs. ....min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: mechanic
11. Industry or business: retired
FATHER
12. Name: unk.
13. Birthplace: unk.
MOTHER
14. Maiden name: unk.
15. Birthplace: unk.
16. Informant: Hospital Records
Address: Catonsville 28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-3-47 (month) (day) (year)
Cemetery or crematory: Spring Grove State Hospital
Location: Catonsville 28, Maryland
18. Funeral director: Spring Grove State Hospital
Address: Catonsville 28, Md.
19. 4-3 1947 (Date rec'd by registrar) Harry J. Miller, deputy, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18 1946, at 5-25 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
and that I last saw h.... alive on ....19....

Immediate cause of death: Acute cardiac failure
Due to: Cardio vascular disease
Due to: fracture neck left femur
Other conditions:
(Include pregnancy within 3 months of death)
DURATION:

Major findings of operations: .... Date of op. ....
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Sept 2 1946
Where did injury occur? Catonsville (City or town) Baltimore (County) Md (State)
Injured at home, farm, industry, public place (where?): Hospital
Means of injury: fall from chair during commitment Injured at work?

23. SIGNATURE: G. M. Kiefer, for Edw. Wm. Bell, Deputy Med. Ex. M. D. or other
Address: 1010 Leeds ave Date signed: 10-18-46

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

69740

Reg. Dist. No. 440

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 1/2 hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 4 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 127 Prince George St.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: JOHN W. CATLIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7/29/1889

8. AGE: Years	Months	Days	If less than one day
57	2	5	hrs. min.

9. Birthplace: Herring Bay, Maryland (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business
12. FATHER — Name: William Catlin
13. FATHER — Birthplace: Maryland
14. MOTHER — Maiden name: Alice Dore
15. MOTHER — Birthplace: Maryland
16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 7 1946 (month) (day) (year)
Cemetery or crematory: U.S. National Cem.
Location: Annapolis Md.
18. Funeral director: Wilbur Lamborn
Address: 410 Liberty Heights Ave
19. 10/7/46 19 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4 1946 at 9:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4 1946, to Oct. 4 1946 and that I last saw him alive on October 4 1946

Immediate cause of death	DURATION
Peritonitis	unknown
Due to Rupture of abscess about gall bladder	unknown
Due to Empyema of gall bladder	unknown
Other conditions Cholelithiasis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: substantiated as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLINICAL DIRECTOR
M. D. or other
Address: VAH FT. HOWARD, MD. Date signed: 10-5-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

09741

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Arbutus (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Arbutus (If outside city or town limits, write RURAL and give nearest town)
Street No. 1338 Poplar Ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Marriott Chaney

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Pearl Chaney
6.(c) If alive, give age: 7 years

7. Birth date of deceased (mo., day, yr.): Feb 2, 1860

8. AGE:

Years	Months	Days	If less than one day
86	8	18	hrs. min.

9. Birthplace: Odenton Md (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:
12. FATHER — Name: Thomas Chaney
13. FATHER — Birthplace: Md
14. MOTHER — Maiden name: Elizabeth Marriott
15. MOTHER — Birthplace: Md
16. Informant: Edith E. O'Loughlin
Address: 1338 Poplar Ave - Arbutus
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 23. 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: A. A. Co. Md
18. Funeral director: Mr & Mrs. John W. Teufel & Son
Address: 5311 Edmondson Ave
19. Oct 22 1946 (Date rec'd by registrar) Teufel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 20 1946 at 6 19 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 24, 1946 to 10/20/ 1946 and that I last saw him alive on 10/20/46 19

Immediate cause of death	DURATION
Endarteritis obliterans	6 or
(gangrene left foot and leg)	7 mos.
Due to	
Due to	
Other conditions - - - - -	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry Deitel M.D. M. D. or other
Address: 1226 Hanover St. Date signed: 10/21/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51)

CERTIFICATE OF DEATH

09742

Reg. Dist. No. 38 1

1. PLACE OF DEATH:
County: Baltimore
City or town: Brooklandville Rural, Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, institution, or street address where death occurred: home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md Baltimore County: Baltimore
City or town: Brooklandville Rural, Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rurel, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Francis Cochran Jr

3.(b) Social Security Number

4. Sex: Male

5. Color or race: white

6.(a) Single (married) widowed, or divorced

6.(b) Name of husband or wife: Ottolie Wickes Brewster Cochran

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): Mar 20 1906

8. AGE: Years: 40 Months: 6 Days: 27 If less than one day: hrs. min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual occupation: Johns Hopkins Physics Lab.

11. Industry or business: Personal Div War Service

FATHER
12. Name: William Francis Cochran
13. Birthplace: Yonkers N.Y.

MOTHER
14. Maiden name: Nina Gill
15. Birthplace: Balto Md

16. Informant: Alexander D. Cochran
Address: Woodbrook Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 19 1946 (month) (day) (year)
Cemetery or crematory: St Thomas'
Location: Garrison Forest Md

18. Funeral director: Henry W. Jenkins Sons Co
Address: McCulloh & Orchard Sts

19. 10/18 1946 (Date rec'd by registrar) A.W. Medinger Registrar

1-25-300

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17 1946 at 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1945 to Oct 17 1946 and that I last saw him alive on Oct 17 1946

	DURATION
Immediate cause of death: Inanition, intestinal hemorrhage	
Due to: embryonal carcinoma of testis with metastases	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Ca testis metastases to supraclavicular area Date of op. Oct 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John Howard M.D.
M. D. or other
Address: Johns Hopkins Hospital Date signed Oct 17, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

09743

Reg. Dist. No. 38 1

1. PLACE OF DEATH:

County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 604 Woodbine Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 604 Woodbine Ave.

(If rural, give LOCATION)

2.(c) If veteran, name war WW

3. (a) FULL NAME Madeline Elizabeth Cook

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or wife Dr. Carlton M Cook

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 18 1864

8. AGE: Years	Months	Days	If less than one day
82	2	7	..... hrs. ..... min.

9. Birthplace New Zealand (Town, county, and state)

10. Usual occupation At Home

11. Industry or business Self

FATHER 12. Name Absalom Carey

13. Birthplace U.S.

MOTHER 14. Maiden name Elizabeth Hahn

15. Birthplace Hanover - Germany

16. Informant Carlton E Cook

Address 437 E 20th St - Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/28/46 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Baltimore Maryland

18. Funeral director Wm Cook Inc

Address 217 S Bul St, Balto Md

19. Oct 28 1946 (Date rec'd by registrar) A. W. Redmond Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1946 to Oct 25 1946 and that I last saw her alive on Oct 25 1946

Immediate cause of death	DURATION
Carcinoma Breast	2½ yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma -

Date of op. 2yrs ago.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Hunt Kelly M.D.

M. D. or other

Address Towson Md Date signed Oct 26. 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

09744

Reg. Diat. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Pikesville
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death?:
Hospital, institution, or street address where death occurred:
#20 Hawthorne Ave.
How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 20 Hawthorne Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles William Cooper

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Josephine Wise Cooper
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): May 2, 1861

8. AGE: Years	Months	Days	If less than one day
85	5	22	...hrs. ...min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Bushman (Tailor)
11. Industry or business:

FATHER
12. Name: James Cooper
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Josephine W. Cooker
Address: 20 Hawthorne Av Pikesville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/25/46 (month) (day) (year)
Cemetery or crematory: St Stenislaus
Location: Baltimore Md

18. Funeral director: Fred H Newell
Address: Pikesville 8 md

19. 10/25/1946 (Date rec'd by registrar) E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24th, 1946 at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11, 1946, to October 24, 1946
and that I last saw him alive on October 24, 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 days
(First stroke-June 1944)	
Due to: (Second stroke -October 23.1946)	2 days
Due to:	
Other conditions: Old age.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E. E. Nichols M.D.
M. D. or other
Address: Pikesville-8, Md. Date signed: 10/25/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

8

Reg. Dist. No. 09745 420

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Balto.

City or town Halethorpe Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war World War II

3.(a) FULL NAME Pendleton ~~Penlton~~ R. Davis

3.(b) Social Security Number

4. Sex: Male

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Margaret V. Davis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 26, 1912

8. AGE: Years: 34 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Bristol Va. (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business:

FATHER 12. Name: Wesley Davis

13. Birthplace: Bristol Va.

MOTHER 14. Maiden name: Signora Pendleton

15. Birthplace: Bristol Va.

16. Informant: Margaret Davis

Address: Halethorpe Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 30 1946 (month) (day) (year)

Cemetery or crematory: Arbutus Memorial

Location: Baltimore County

18. Funeral director: Mr. Katie R. Williams

Address: 3229 W. Lanvale St.

19. 10/29 1946 (Date rec'd by registrar) A. W. Hedgett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 1946 at 3:12 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10-27- 1946 to 10-27- 1946 and that I last saw him alive on not seen alive 19..

Immediate cause of death	DURATION
Gun shoot wound in left lung and heart	Instant
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Murder Date of 10-27-'46

Where did injury occur? Halethorpe, Baltimore, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Arbutus Memorial

Means of injury Gun shot wound Injured at work? Pk.

23. SIGNATURE D. D. Caples, M. D. Exam. med. M. D. or other

Address Reisterstown, Md. Date signed 10-28-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49)

CERTIFICATE OF DEATH

09746

Reg. Dist. No. 4-10

1. PLACE OF DEATH:
County Baltimore
City or town Rural Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
7920 Old Philadelphia Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Rosedale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7920 Old Philadelphia Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary de Luca

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

8.(b) Name of husband or wife Abramo De Luca Abraham
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 25 1895

8. AGE: Years	Months	Days	If less than one day
51	6	23	..... hrs. ..... min.

9. Birthplace Italy (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Domenico Di Luigi
13. Birthplace Italy

MOTHER
14. Maiden name Anna?
15. Birthplace

16. Informant Abramo De Luca
Address 7920 Old Philadelphia Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 21 1946 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Belair Rd. Balt. MD
18. Funeral director Frank Della Noce
Address 52 N. Morley St.

19. 10-19 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1946, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 1946, to Oct. 18 1946
and that I last saw her alive on Oct. 17, 1946

	DURATION
Immediate cause of death Generalized Carcinomatosis	6 months
Due to carcinomatosis peritonei	
Due to Carcinoma of ovary	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE A. L. Koloday M. D. or other
Address Ridge Rd. Balt. 6, Md. Date signed Oct 18, 1946

VS A15 9.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

03747

Reg. Dist. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Baltimore

City or town Cockeysville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year — 1 month

Hospital, Institution, or street address where death occurred:
Masonic Home, Cockeysville Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 737 Virginia Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth M. Eckman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Milford W Eckman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 7th 1870

8. AGE: Years	Months	Days	If less than one day
76	—	21	..... hrs. ..... min.

9. Birthplace Near Freelands - Baltimore Co Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John H. Merryman

13. Birthplace Cockeysville Md

MOTHER 14. Maiden name Rebecca Marsh

15. Birthplace Baltimore Co.

16. Informant Laura M. Schroeder

Address Masonic Home, Cockeysville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 31. 46 (month) (day) (year)

Cemetery or crematory Ashury Cemetery

Location Reisterstown Md

18. Funeral director Wm Cook

Address 2d Paul & Preston St.

19. Oct. 29 1946 L M Schroeder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 October 1946, at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Oct 1946, to 28 Oct. 1946

and that I last saw h.. alive on 28 October 1946

Immediate cause of death	DURATION
Heart failure	
Auricular Fibrilation	2 days
Due to Arterio sclerosis	At least
and Hypertension	14 mons.
Due to	
Other conditions { Old healed fracture left hip	Right ankle

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter T. Kees M. D.
M. D. or other

Address Cockeysville, Md. Date signed 28 Oct. 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09748 P

Reg. Diat. No. 381

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 134 E. Chesapeake Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Howard Fields

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife Etta Fields
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June - 1887

8. AGE: Years 59 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Gardner
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Etta Fields
Address 134 Chesapeake Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-9-46 (month) (day) (year)
Cemetery or crematory Pleasant Rest
Location Towson
18. Funeral director Sam'l. W. Chase & Son
Address 628 N. Fulton Ave. Balto.
19. 10/7/46 (Date rec'd by registrar) 19 ..... A. W. Beeuwkes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 19 46, at 6 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h... alive on ..... 19 .....

	DURATION
Immediate cause of death Heart disease, chronic myocarditis, decompensated	1943
Due to Hypertension	1943
Due to Arteriosclerosis	Unknown
Other conditions Cerebral hemorrhage, site not stated	1943

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Rollin L. Hudson MD DME M. D. or other
Address Towson 4 Md Date signed 10/6/46.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C9749 8

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, Institution, or street address where death occurred:
Veterans Adm. Hospital, Ft. Howard, Md
How long in hospital or institution 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 803 North Calvert Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War one

3.(a) FULL NAME: Harry H Finley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Florence Finley (Wife)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 17, 1891

8. AGE: Years 55 | Months 5 | Days 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: California
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: James Finley (deceased)
13. Birthplace: California

MOTHER
14. Maiden name: Martha Potter
15. Birthplace: California

16. Informant: Clinical records, Vets. Adm Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 23 1946 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Baltimore Md
18. Funeral director: Leonard L. Covington
Address: 21 W. 25th St.

19. 10/21/46 (Date rec'd by registrar) 19..... A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20, October, 1946, at 12:45 AM.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12, October 1946, to 20, October 1946
and that I last saw him alive on 20, October 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage with right hemiplegia.	17 days
Due to: Hypertension, arterial	5 mo, plus
Due to:	
Other conditions: Hypertensive heart disease	5 mo, plus
Residuals of left hemiplegia	5mo, plus

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison
Robert M. Cullison, M.D. Clin. Dir. M.D. or other
Address: V.A. Fort Howard, Md. Date signed .....

VS-A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09750

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months, 14 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 8 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 832 W. 37th St.
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME E.
William Fleischman

3.(b) Social Security Number -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	m

6.(b) Name of husband or wife: Marie Albrecht Fleischman

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): 10/13/1865

8. AGE: Years	Months	Days	If less than one day
81		17	hrs. min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation: clothing cutter

11. Industry or business: clothing

FATHER — 12. Name: John Fleischman

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: ~~John Fleischman~~ Julia

MOTHER — 15. Birthplace: Germany

16. Informant: Hospital Records

Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 2-1946 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore, Maryland

18. Funeral director: Burgee Funeral Home

Address: 3331 Falls Road

19. 11/2 (Date rec'd by registrar) 19 46 D.W. Hedrick Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 19 46, at 12:55p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16 19 46, to October 30 19 46 and that I last saw him alive on October 30 19 46

Immediate cause of death	DURATION
Terminal broncho-pneumonia	24 hours
Due to: Hypertensive cardiovascular disease.	Indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville 28, Md. Date signed: 10/31/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-0)

CERTIFICATE OF DEATH

C9751 4

Reg. Dist. No. 441

1. PLACE OF DEATH:
County Baltimore
City or town Essex (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred 25 Crafton Rd.
How long in hospital or institution? 2 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Essex (If outside city or town limits, write RURAL and give nearest town)
Street No. 25 Crafton Rd (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Forsythe

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Christina Forsythe
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 13, 1862

8. AGE: Years 84 | Months 4 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Scotland (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name William Forsythe
13. Birthplace Scotland

MOTHER 14. Maiden name Catherine Reid
15. Birthplace Scotland

16. Informant (Mrs.) M. Elizabeth Forsythe
Address 25 Crafton Rd Essex Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 11 1946 (month) (day) (year)
Cemetery or crematory Druid Ridge Cem
Location Pikesville Balto Co Md

18. Funeral director Lorenz Byers
Address 5005 Park Heights Ave

19. 10/9/46 (Date rec'd by registrar) A W. Hedrick Registrar

JS

1-25-

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8th 1946 at 9 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2nd 1946 to Oct 8th 1946
and that I last saw him alive on Oct 7th 1946

Immediate cause of death	Cerebral Hemorrhage	DURATION 1 wk.
Due to	Arteriosclerosis	
Due to	Senility	
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thomas B. Hayley, M.D.
M. D. or other
Address 815 Eastern Ave Baltimore Md. Date signed 10/8/46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1 Transcript
Burial Permit

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-6)

CERTIFICATE OF DEATH

09752 30 Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No. 646 Orpington Road (If rural, give LOCATION)
2.(a) If veteran, name war ***

3.(a) FULL NAME Katherine B. Fox

3.(b) Social Security Number ***

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F. M.	W	Widowed

6.(b) Name of husband or wife Charles W. Fox
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Feb. 14 ? 1873

8. AGE: Years	Months	Days	If less than one day
73 ?	?	?	..... hrs. ..... min.

9. Birthplace Burkettsville Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

16. Informant Mr. Harry L Fox
Address 646 Orpington Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 4, 1946 (month) (day) (year)
Cemetery or crematory Church Cemetery
Location Burkettsville Md.

18. Funeral director Geo. W. Little
Address 2700 Edmondson Ave. 23

19. 10/3 1946 (Date rec'd by Registrar) A.W. Hedrick M.D. Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 1946 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March, 23, 1943 19.. to Oct, 1, 1946 19..
and that I last saw her alive on Sept, 30, 1946 19..

Immediate cause of death	DURATION
Carcinoma of the Uterus.	4 yrs
Due to --	
Due to — —	
Other conditions — —	

(Include pregnancy within 3 months of death)

Major findings of operations Pan Hysterectomy Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE S. Lloyd Johnson M. D. or other
Address Catonsville Md Date signed 10-1-46

Johnson
610 Frederick Rd

Dr. White

MARYLAND STATE DEPARTMENT OF HEALTH
~~BALTIMORE CITY HEALTH DEPARTMENT~~

CERTIFICATE OF DEATH

Registered No. 38

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore ~~City~~, Maryland
(b) Street address 1761 Joppa Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) ~~City or town~~ Co. Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1761 Joppa Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Magdelena Francés

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John C. Francés
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1872

8. AGE: Years	Months	Days	If less than one day
74	8	12	hr. min.

9. Birthplace Baltimore Co, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Peter Eppig
13. Birthplace Germeny

MOTHER
14. Maiden Name Elizabeth Henkle
15. Birthplace Baltimore

16 (a) Informant Miss Margaret H. Francés
(b) Address 1761 Joppa Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) 11/, 19 (b) 46 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1946 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to 1946 and that I last saw h.er alive on Oct 31 1946.

	Duration
Immediate cause of death Acute Circulatory failure from	7 hours
Due to Coronary Thrombosis	
Due to Hypertensive Cardio Vascular disease	10 years
Other Conditions Angina pectoris	10 years

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome E. White M.D.
Address 5214 Harford Rd Date signed Nov 1, 46

VS 150

1-.35

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (104-e)

CERTIFICATE OF DEATH

C9754 381
Reg. Dist. No.

P

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Western Run
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME John Merryman Franklin Jr

3.(b) Social Security Number 219-22-5223

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 10, 1925

8. AGE: Years 21 | Months | Days | If less than one day hrs. min.

9. Birthplace New York City, N.Y. (Town, county, and state)
10. Usual occupation Student
11. Industry or business University of Maryland
FATHER 12. Name John Merryman Franklin
13. Birthplace Cockeysville, Md.
MOTHER 14. Maiden name Emily Sophia Hammond
15. Birthplace New York City, N.Y.
16. Informant Emily S. Franklin — Mother
Address Cockeysville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 23 1946 (month) (day) (year)
Cemetery or crematory Sherwood 10/23/46
Location Cockeysville, Maryland
18. Funeral director H. K. Mears and Son
Address 805 N. Calvert Street
19. 10/23 19 46 (Date rec'd by registrar) Registrar

1-25 — 380-10

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1946, at 9:7 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from None 19 to 19
and that I last saw h alive on 19
Immediate cause of death Gun shot, through head - 45 pistol. — DURATION 10/21/46
Due to Suicide — 10/21/46
Due to Depression over injured back — 2 yrs
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 10/21/46
Where did injury occur? Cockeysville (City or town) Baltimore (County) Md (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Rollin L. Hudson M.D. P.M.E. (M. D. or other)
Address Towson 4 Md Date signed 10/22/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

09755

CERTIFICATE OF DEATH

Reg. Dist. No. 34

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Baltimore

City or town Fowblesburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Fowblesburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna A. Gill

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife William T. Gill

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 1 - 1858

8. AGE:

Years	Months	Days	If less than one day
87	10	29	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Jesse Upperco

13. Birthplace Md

MOTHER 14. Maiden name Mary Warren

15. Birthplace Md

16. Informant Robert Howard

Address Fowblesburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 1/46 (month) (day) (year)

Cemetery or crematory St. Pauls

Location Balto Co.

18. Funeral director Edw A Tipton

Address Hampstead Md

19. Oct 31 1946 (Date rec'd by registrar) Cyril E Fowble M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, at 8:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 26 1946 to October 30 1946

and that I last saw her alive on October 29 1946

	DURATION
Immediate cause of death Uraemia	Acute
Due to Arterio-Sclerotic Cardio-Vascular Renal Disease	6 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maurice C. Porterfield M.D. or other

Address Hampstead, Md Date signed 10-30-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 09756 301

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 2 months, 20 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution 2 years, 2 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3405 Pinkney St.
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME William Aza Gladman

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	w

6.(b) Name of husband or wife Katherine McKewin

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 24, 1861

8. AGE:

Years	Months	Days	If less than one day
85	3	7	...hrs. ...min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation mortician

11. Industry or business own business

FATHER
12. Name Theophilis Gladman
13. Birthplace Washington, D.C.

MOTHER
14. Maiden name Mary Flenner
15. Birthplace Washington, D.C.

16. Informant Hospital Records
Address Catonsville 28, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof Nov 2, 1946 (month) (day) (year)

Cemetery or crematory London Park

Location 3801 Frederick Rd.

18. Funeral director Harry A. Wiltshe

Address 4101 Edmondson Ave.

19. 11/2 1946 A. W. Hedrick Registrar
(Date rec'd by registrar)

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1946, at 2:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11 1944, to October 31 1946 and that I last saw him alive on October 31 1946

	DURATION
Immediate cause of death Chronic Myocarditis	Indef.
Due to Generalized arteriosclerosis.	Indef.
Due to	
Other conditions arteriosclerotic gangrene of the right foot.	

(Include pregnancy within 3 months of death)

Major findings of operation Amputation right femur, junctional upper and middle 1/3. Date of op. 10/26/46

Autopsy results no.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gordon Funk M. D. or other
Catonsville 28, Md.

Address Date signed 10/31/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45.

09757 B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 410

1. PLACE OF DEATH

County: Baltimore

City or town: Dundalk Rfd.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 245 Trappe Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Dorothy Mae Gray

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Beverly R Gray

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 5 1900

8. AGE: Years: 46 | Months: | Days: 3 | If less than one day: hrs. min.

8. Birthplace: Arkansas (Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER — 12. Name: George C Morris

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Beverly R Gray

Address: 245 Trappe Road

17. (Burial, cremation, or removal. Which?) Burial — Date thereof: Oct 11 1946 (month), (day), (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore Md.

18. Funeral director: Harry A. Annacost

Address: 4204 Ridgewood Ave

19. 10/9/46 (Date rec'd by registrar) 19 ... C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-8- 1946 at 1.55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9-9- 1946, to 10-8 1946

and that I last saw her alive on 10-8- 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 hrs
Due to: Hypertension encephalopathy with uremia	
Due to: (Chronic nephritis)	1 year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Eugene F Neary M.D. M. D. or Other

Address: 7001 Mornington Rd Dundalk, Md Date signed: 10-8-46

I-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09758

Reg. Dist. No. 32

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 1 mo., 27 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Maryland Tuberculosis San.
How long in hospital or institution? 0 yrs., 1 mo., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland
County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2112 E. Madison Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mrs. Mary C. Grogan

3. (b) Social Security Number: 213-03-9484

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Edward J. Grogan
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): August 17, 1896

8. AGE: Years	Months	Days	If less than one day
50	1	28	... hrs. ... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Tailor
11. Industry or business:

FATHER
12. Name: Benjamin Klug
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Catherine Wagner
15. Birthplace: Baltimore, Maryland

16. Informant: Mrs. Mary C. Grogan
Address: 2112 E. Madison St., Balto., Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Oct. 19, 1946 (month) (day) (year)
Cemetery or crematory: Holy Redeemer Cemetery
Location: 4430 Belair Rd., Balto., Md.

18. Funeral director: Joseph J. Herr & Sons
Address: 3001 Kentucky Ave., Balto., Md.

19. Oct. 15, 1946 (Date rec'd by registrar) Earl T. Webster, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15, 1946, at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18, 1946, to Oct. 15, 1946 and that I last saw her alive on October 15, 1946

Cause	DURATION
Immediate cause of death: Pulmonary Tuberculosis	10 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Enteritis	3 Mos.
Diabetes Mellitus	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Stewart S Shaffer M.D.
M. D. or other
Address: Mount Wilson, Md. Date signed: 10/15/46

Recd - 10-18-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-11)

CERTIFICATE OF DEATH

09759

Reg. Dist. No. 32

P

1. PLACE OF DEATH:
County BALTO
City or town PIKESVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County BALTO.
City or town PIKESVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. CAMPFIELD ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME GRACE I HADAWAY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEM	WHITE	WIDOW

6.(b) Name of husband or wife NOT KNOWN
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) JULY. 11- 1865

8. AGE: Years	Months	Days	If less than one day
81	3	0	hrs. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)
10. Usual occupation -
11. Industry or business

FATHER
12. Name ASA WESSELS
13. Birthplace ?

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant AVONDALE HOME
Address CAMPFIELD ROAD
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Oct. 13 1946 (month) (day) (year)
Cemetery or crematory IMMANUAL CEM
Location LAURAVILLE BALTO MD
18. Funeral director Mrs Chas A G Rohde
Address 2327 Edmondson Ave
19. 10/12 1946 Rev. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1946 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept - 10 1946 to Oct - 11 1946; and that I last saw h.e.r. alive on Oct - 11 - 1946

Immediate cause of death	DURATION
1) - Arterio - Sclerotic Heart Disease	10 yrs.
Due to - Generalized Arterio Sclerosis -	5 yrs. -
Other conditions - Chronic Nephritis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results - None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Earl L. Chambers M.D.
M. D. or other
Address 4108 - Liberty Hts. Date signed 10/12/46.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

8

09760

Reg. Dist. No. 38-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto
City or town: Ansonia
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 7102 Wardman Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Ansonia
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7102 Wardman Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Louis Benjamin Haines

3. (b) Social Security Number: 215-10-4257

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Linda B. Haines
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 22nd 1896

8. AGE: Years	Months	Days	If less than one day
50	5	20	hrs. min.

9. Birthplace: Cuba N.Y.
(Town, county, and state)
10. Usual occupation: Supervisor
11. Industry or business: Western Electric Co.
FATHER 12. Name: Benjamin Haines
13. Birthplace: N.Y.
MOTHER 14. Maiden name: Lura Alsworth
15. Birthplace: N.Y.
16. Informant: Linda B. Haines
Address: 710[illegible] Wardman Rd.-Stonleigh
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/15/46 (month) (day) (year)
Cemetery or crematory: [illegible]id Ridge
Location: [illegible]sville Md.
18. Funeral director: William Cook Inc
Address: 1217 St. Paul St.
19. 10/14 (Date rec'd by registrar) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 1946 at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19 to 19
and that I last saw h alive on 19
Immediate cause of death: Heart disease, coronary occlusion — DURATION: 10/12/46
Due to: Heart disease, muscular, coronary arteriosclerosis — DURATION: March 1946
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Rollin C. Hudson M.D. D.M.E.
M. D. or other
Address: Towson Md Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

★ 09761

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkton Md. R. D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Baltimore.
City or town: Rural near Parkton.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5 mi. South of Parkton.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alice May Hamilton.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow.

6.(b) Name of husband or wife: Albert M. Hamilton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 2, 1879.

8. AGE:

Years	Months	Days	If less than one day
67	3	7	..... hrs. ..... min.

9. Birthplace: Wiseburg Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home.
FATHER 12. Name: H. B. Miller.
13. Birthplace: Balto. Co., Md.
MOTHER 14. Maiden name: Margaret E. Cooper
15. Birthplace: Balto. Co., Md.
16. Informant: Clifton Hamilton.
Address: Parkton, Md. R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 12, 1946 (month) (day) (year)
Cemetery or crematory: Fosters Cemetery.
Location: Parkton, Md. R.D.
18. Funeral director: Jacob Hartenstein
Address: New Freedom Pa.
19. Oct 11 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9, 1946 at 7:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19..., to Oct 9 1946
and that I last saw h[illegible] alive on Oct 8 1946
Immediate cause of death: Coronary Thrombosis — DURATION: 2 days
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Milner Bortner M D.
M. D. or other
Address: White Hall Date signed: Oct 9. 46


RECEIVED
OCT 26 1946
OAKLAND, CAL.

Maryland State Department of Health

~~BALTIMORE CITY HEALTH DEPARTMENT~~ (61)

CERTIFICATE OF DEATH

(8) Registered No. 3011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
(a) Baltimore ~~City~~, Maryland Catonsville
(b) Street address
(c) Hospital or institution:
Opitz Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED: 69762
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4110 Fernhill Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Robert E. Lee Hart

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: m
5. Color or race: w
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Floy Bragdon Hart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1865

8. AGE: Years 81 | Months 7 | Days 15 | If less than one day: hr. min.

9. Birthplace: Dorchester Co., Md.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: George Hart
13. Birthplace: Dorchester Co., Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mr. P. A. B. Hoblitzell
(b) Address: 910 W. University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-24-46 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: Baltimore, Md

19 (a) 10/24/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22-1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1946 to 19, and that I last saw h[illegible] alive on Oct. 22 1946

Immediate cause of death: Chronic Myocarditis — Duration: years

Due to: Diabetes — Duration: 1

Due to: Arterio Sclerosis.

Other Conditions: Old Age.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Arthur C. Blake M. D.
Address: Med. Arts Bldg. Date signed

VS 150

1-35

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

C9763

Reg. Dist. No. 44

1. PLACE OF DEATH

County Balto.

City or town Middle River

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

526 Hampden Rd.

How long in hospital or institution? 25 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Middle River

(If outside city or town limits, write RURAL and give nearest town)

Street No. 526 Hampden Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Carl Heim Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna Marie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 13 1897

8. AGE:

Years	Months	Days	If less than one day
49			..... hrs. ..... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business -

FATHER

12. Name Michael Heim

13. Birthplace Germany

MOTHER

14. Maiden name Eleanora Nagel

15. Birthplace Md.

16. Informant Anna Marie Heim (wife)

Address 526 Hampden Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/21/46 (month) (day) (year)

Cemetery or crematory Oak Lawn

Location Eastern Ave. Rd.

18. Funeral director John J. Connelly.

Address 418 Eastern Ave. Essex 21, Md.

19. 10/18/46 (Date rec'd by registrar) 19 46 J. J. Connelly (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 19 46 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 19 46 to Oct 17 19 46 and that I last saw him alive on Oct 17 19 46

Immediate cause of death	DURATION
Coronary occlusion	Instant
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. M. Carmine M.D. M. D. or other

Address Deputy med. Examiner Baltimore, Md. Date signed 10/17/46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15


RECEIVED
OCT 28 1996

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-2

09764 8

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 9 mo., 20 days.
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
How long in hospital or institution? 1 yr., 9 mo., 20 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Monta.
City or town Chevy Chase,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6619 Hillandale Rd., Apt. 21
(If rural, give LOCATION)
2.(a) If veteran, name war WW I

3.(a) FULL NAME JAMES MONROE HILL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Norma M. Hill
8.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 9/4/97

8. AGE: Years	Months	Days	If less than one day
49	1	23	..... hrs. ..... min.

9. Birthplace Louisville, Kentucky (Town, county, and state)
10. Usual occupation Unemployed
11. Industry or business

FATHER
12. Name Adam Pebies Hill
13. Birthplace North Carolina

MOTHER
14. Maiden name Frances Graves
15. Birthplace Virginia

18. Informant Registrar's Office, Clin. Records
Address Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 29 Oct. 1946 (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington County, Va.

18. Funeral director S.H.Hines Co.
Address 2901 14th St., NW Washington, D. C.

19. 10/28 (Date rec'd by registrar) 19 46 A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 19 46 at 7:10AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Jan 19 45 to October 27 19 46 and that I last saw him alive on October 27 19 46

Immediate cause of death	Multiple Sclerosis	DURATION 25 yrs.
Due to		
Due to		
Other conditions	Inanition	22 mon.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Kenneth W. Taber M. D. or other
Address Vet. Adm. Hosp. Ft. Howard Md. Date signed 27 Oct 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

County.

BALTIMORE ~~CITY~~ HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 42

1. PLACE OF DEATH:

(a) Baltimore ~~City~~, Maryland

(b) Street address Arbutus Avenue / Annapolis Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Catonsville

(If outside city of town limits, write RURAL and give town)

(d) Street No. Arbutus Ave / Annapolis Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Addie Margret Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married.

6 (b) Name of husband or wife David M. Hoffman

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) November 1901

8. AGE: Years	Months	Days	If less than one day
44	11	2	hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER

12. Name John East

13. Birthplace Baltimore, Md

MOTHER

14. Maiden Name Ella Baring

15. Birthplace Baltimore, Md.

16 (a) Informant David M. Hoffman

(b) Address Arbutus Avenue / Annapolis

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8 46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Rd

18 (a) Funeral director Edward Loudon

(b) Address 2359 Wash Blvd

19 (a) 10/7/46 (Date rec'd by registrar) (b) A. W. Bedrick Registrar

VS 150

1-33

MEDICAL CERTIFICATION

20. DATE OF DEATH October - 5 - 1946, at 9 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Oct - 5 - 1946, and that I last saw h e alive on Oct - 5 - 1946.

Immediate cause of death	Duration
2 Cancer of uterus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Walter H. Sonnenfeldt M. D.

Address 2708 Hollins Ferry Rd Date signed 10/5/46

Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (134-P)

CERTIFICATE OF DEATH

(5) D 09766

Reg. Diat. No. 42

1. PLACE OF DEATH:
County: Baltimore
City or town: Halethorpe Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Penna R R tracks near
How long in hospital or institution? Jan 20 or 21

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto Co
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: II32 Homestead St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Irene Virginia Hough

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Hugo Hough
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct 6 1909 ?

8. AGE: Years	Months	Days	If less than one day
37	0	14 ?	hrs. min.

9. Birthplace: West Va
(Town, county, and state)
10. Usual occupation: Seamster
11. Industry or business:
FATHER 12. Name: Cass Fisher
13. Birthplace: Unknown
MOTHER 14. Maiden name: Viola B Edmonds
15. Birthplace: Unknown
16. Informant: John Hugo Hough
Address: II32 Homestead St Balto Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/23/36 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Balto md
18. Funeral director: Edward Fowlson
Address: 2359 Wash Blvd
19. Oct 22 1936 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 20 1936 about at 10-45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Body mangled	
Due to: Cut to pieces	
Due to: by train on Penn R R	
Other conditions: Jumped in front of train	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of Oct 20 36
Where did injury occur? Halethorpe Balto md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Penn R R track
Means of injury: Struck by train Injured at work? no

23. SIGNATURE: Geo McKinley Lindsay Med M. D. or other
Address: 1010 Lindsay Date signed 10-24-36

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

09767

Reg. Diat. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 1 mo., 14 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 1 yr., 1 mo., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 17 Egges Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Agnes Hubbard

3. (b) Social Security Number: # Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Mr. Henry Hubbard
6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): July 7, 1917

8. AGE: Years	Months	Days	If less than one day
29	3	1	hrs. min.

9. Birthplace: Knollwood, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: James Grimes
13. Birthplace: Maryland

MOTHER
14. Maiden name: Isabelle Scrivinor
15. Birthplace: Maryland

16. Informant: Mrs. Agnes Hubbard
Address: 17 Egges Lane, Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 10, 1946 (month) (day) (year)
Cemetery or crematory: McKendree Cemetery
Location: West Friendship, Howard Co., Md.

18. Funeral director: C. Harry Weer
Address: Sykesville, Maryland

19. Oct. 8, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

Rec'd - 10-10-46

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8, 1946, at 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24, 1945, to October 8 1946 and that I last saw her alive on October 8, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 Yrs. 9 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Laryngitis	1 Yr. 9 Mos.

(Include pregnancy within 3 months of death)

Major findings of operations: No operation
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart S Shaffer M.D. M. D. or other
Address: Mount Wilson, Md. Date signed: 10/8/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 09768

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 5 mos., 16 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 5 mos., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Pr. Geo. Co.

City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 117-48th Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. Richard L. Hunt

3.(b) Social Security Number: 578-22-0534

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 3, 1925

8. AGE: Years	Months	Days	If less than one day
21	4	12	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER
12. Name: Charles E. Hunt
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Mary A. Geary
15. Birthplace: Washington, D. C.

16. Informant: Richard L. Hunt
Address: 117 - 48th Ave., Capitol Hgts. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 28, 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland, Pr. Geo. Co., Md.

18. Funeral director: W. W. Chambers
Address: 517 11th St., S.E., Wash., D.C.

19. Oct. 25, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

Rec'd - 10-28-46 - Dr. E. Nichols, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25, 1946, at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9, 1946, to Oct. 25, 1946 and that I last saw him alive on October 25, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 Yrs. 3 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D.
M. D. or other

Address: Mount Wilson, Md. Date signed: 10/25/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-c)

CERTIFICATE OF DEATH

09769

Reg. Diat. No. 37

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville (Rural)

(If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Cockeysville (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Ashland Road

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Samuel M. Hunt.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Emma V (L-Eagle)

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Nov. 16, 1872

8. AGE: Years	Months	Days	If less than one day
73	10	19	hrs. min.

9. Birthplace: Balto. Co., Md. (Town, county, and state)

10. Usual occupation: General Laborer

11. Industry or business

FATHER 12. Name: Wm. H. Hunt.

13. Birthplace: Balto. Co., Md.

MOTHER 14. Maiden name: Charlotte Merryman

15. Birthplace: Balto. Co. Md.

16. Informant: Mrs. S. M. Hunt.

Address: Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 6, 1946 (month) (day) (year)

Cemetery or crematory: Glenmalura

Location: Monkton, Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

Oct 6 — 19 — 46 Wilmer C. Ensor

(Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 5 19 46 at 6 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 20 19 46, to May 20 19 46 and that I last saw h alive on May 20 19 46

Immediate cause of death	DURATION
Cerebral Embolism	
Due to Valvular Heart disease	Unk
Due to Rheumatic fever	Unk
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Bennett A. Stam M. D. or other

Address: Luthervill — Date signed 10/6/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23a)

CERTIFICATE OF DEATH

09770 4

Reg. Dist. No. 381

1. PLACE OF DEATH:
County Balto
City or town Stoneleigh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Irinacost Nursing Home - Register Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Balto
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2010 Mosby Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Jane Jendrek

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife? John C. Jendrek Sr.
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 23rd - 1870

8. AGE: Years 75 | Months 9 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual occupation At Home
11. Industry or business Self
FATHER 12. Name Moses Carroll
13. Birthplace Ireland
MOTHER 14. Maiden name Margaret McCormick
15. Birthplace Balto. Md.
16. Informant Mrs. Donald Martin
Address 2010 Mosby Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/8/46 (month) (day) (year)
Cemetery or crematory St. Mary's
Location Govans
18. Funeral director William Cook Inc.
Address 1217 St. Paul St.
19. Oct 8 1946 (Date rec'd by registrar) A. W. Jendrek Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5th 1946, at 2.05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1946, to Oct 5 1946, and that I last saw h— alive on Oct 5 1946.

Immediate cause of death	DURATION
Cerebral Hemorrhage	24 hours
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE A. C. Smith M. D. or other
Address 4502 Gibson Ave Date signed Oct 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-d)

09771

FILM No. I 07 OCT 18 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 4-2

1. PLACE OF DEATH:
County: Baltimore
City or town: Relay, 27, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 12 hours
Hospital, institution, or street address where death occurred:
Relay Sanitarium
How long in hospital or institution? about 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.: —
(If rural, give LOCATION)
2.(a) If veteran, name war: not in service

3. (a) FULL NAME: William W. Kimmel

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Sadie Graver Kimmel
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1886

8. AGE: Years	Months	Days	If less than one day
59 ~~60~~	11		..... hrs. ..... min.

8. Birthplace: Frederick Co., Md. (Town, county, and state)
10. Usual occupation: Farmer and Cattle dealer
11. Industry or business

FATHER
12. Name: Frederick J. Kimmel
13. Birthplace: Frederick Co., Md.

MOTHER
14. Maiden name: Anna Gibson
15. Birthplace: Virginia

16. Informant: Uncle- Michael Kimmel
Address: Mt. Airy, Frederick Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 14-1946 (month) (day) (year)
Cemetery or crematory: Home Burying Ground
Location: Near New Londen Md
18. Funeral director: W. E. Galeener
Address: New Market Md

19. Oct 11- 1946 (Date rec'd by registrar) At 11.46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1946 at 8-55a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h ..... alive on ..... 19.....

Immediate cause of death ..... DURATION
Cardiac failure
Due to
Due to: Cardio vascular disease
Other conditions: sudden death
(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Geo. L. M. Kieffer Keep Med & Am Hall
M. D. or other
Address: 1010 Leder ave Date signed: 10-11-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

CERTIFICATE OF DEATH

C9772

Reg. Diat. No. 44

1. PLACE OF DEATH:
County Baltimore. 19.
City or town Sparrows Point.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, Institution, or street address where death occurred: R10 Box 306. Creek Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Bowleys #1.
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.10 Box 306 Creek Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Ellen Kirschner

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed.

6.(b) Name of husband or wife Charles Henry Kirschner, Sr. 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 22. 1872.

8. AGE: Years	Months	Days	If less than one day
73	9	26.	..... hrs. ..... min.

9. Birthplace Preston Co. W. Va. (Town, county, and state)
10. Usual occupation Housework.
11. Industry or business own home.
FATHER 12. Name Daniel Pyles.
13. Birthplace W. Va.
MOTHER 14. Maiden name Miller.
15. Birthplace W. Va.
16. Informant August C. Kirschner
Address 2914 Sparrows Pt. Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 21-46 (month) (day) (year)
Cemetery or crematory Parkwood Mem.
Location Taylor Ave.
18. Funeral director John A. Miller
Address 2364 Jefferson St.
19. 10/21/46 (Date rec'd by registrar) A. W. Jedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 19 46 at 8:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June. 38 to Oct 17 19 46.
and that I last saw h.. alive on October 17 19 46.

Immediate cause of death	DURATION
Coronary Thrombosis.	12 hours.
Due to Arteriosclerosis.	8 yrs.
Due to Hypertensive Cardiovascular disease.	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Louis N. Tollin. M.D. M. D. or other
Address Sparrows Point. Md. Date signed 10/17/46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C9773

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md. County St. Mary's
City or town Hollywood md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Joseph Edward Knott

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Infant

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1945

8. AGE: Years 1 | Months 16.5 | Days 5 | If less than one day hrs. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Joseph Knott
13. Birthplace Maryland

MOTHER 14. Maiden name Bernadine Kilkenford
15. Birthplace Maryland

16. Informant Personal History-Hosp. Records
Address Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct (month) (day) 1946 (year)
Cemetery or crematory St Johnson Cemetery
Location Valley Wood Md.

18. Funeral director W. C. Matthiesley Sons
Address Govanstown Md.

Oct 26 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1946, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5, 1946 to Oct 26 1946 and that I last saw h... alive on Oct. 25. 1946

Immediate cause of death	DURATION
Pulmonary Tb	7 mos
Due to	
Due to	
Other conditions Tuberculosis of Spine	unknown
Tuberculosis meningitis	2 wks.

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. H. Zinkeisen M. D. or other
Address Towson 4, Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

8

09774

Reg. Diat. No. 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.M

1. PLACE OF DEATH

County Balto

City or town Baspeburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos.

Hospital, institution, or street address where death occurred: 22 Elmont Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Balto

City or town ~~Balto~~ Baspeburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 22 Elmont Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME JOSEPH S. KORYTKOWSKI

3. (b) Social Security Number 215-05-5485

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Julia Korytkowski

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 21 1911

8. AGE: Years 34 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Balto md. (Town, county, and state)

10. Usual occupation Supt. Rheem

11. Industry or business Sparrows Point

FATHER 12. Name Frank Korytkowski

13. Birthplace Poland

MOTHER 14. Maiden name Mary Gracezaka

15. Birthplace Poland

16. Informant Mrs Julia Korytkowski

Address 22 Elmont Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 19 1946 (month) (day) (year)

Cemetery or crematory St Stanislaus Cem

Location Dundalk Ave

18. Funeral director Stephen J. Fialkowski Inc

Address 1000 S. Kenwood ave

19. 10/18/46 (Date rec'd by registrar) A. G. Udell Registrar

55

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1946 at 11:50 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945, to Oct 16 1946

and that I last saw h~~im~~ alive on Oct 16 1946

Immediate cause of death Bronchogenic Bronchogenic Carcinoma of Lung. — DURATION 4 mos

Due to Lys. vena Canal obstruction — CWB&W

Due to

Other conditions Lys. vena canal obstruction

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Geller M.D. M. D. or other

Address Date signed 10/17/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

CERTIFICATE OF DEATH

★ 09775 43

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Raspeburg Baltimore 6 Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
7405 Belair Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: As in No 1
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 1

3. (a) FULL NAME: FREDERICK J LASSAHN

3. (b) Social Security Number: 219-01-7763

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Etta M Lassahn
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 2 1889

8. AGE: Years	Months	Days	If less than one day
57	6	16	hrs. min.

9. Birthplace: Baltimore County Md
(Town, county, and state)
10. Usual occupation: Blacksmith
11. Industry or business:
FATHER 12. Name: Frederick W Lassahn
13. Birthplace: Baltimore City
MOTHER 14. Maiden name: Eliza Diimer
15. Birthplace: G ermany
16. Informant: Mrs Fredk J Lassahn
Address: 7405 Belair Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/22/46 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore Md
18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Rd Baltimore 6 Md
19. Oct. 19 1946 (Date rec'd by registrar) Mrs G. L. Riepenseider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18 1946 at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1946 to Oct. 18 1946
and that I last saw h... alive on Oct. 18 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hours
Due to: Cerebral metastases	3 weeks
Due to: Carcinoma of lung, left	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Adam Stevens M. D. or other
Address: 6232 Belair Rd. Balto 6 Date signed: Oct. 18, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

BC 09738 Reg. Dist. No. 44

4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution? 9 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 809 West North Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3.(a) FULL NAME CHARLES E. LAWS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2-14-1893

8. AGE: Years	Months	Days	If less than one day
53	8	2	..... hrs. ..... min.

9. Birthplace Cumberland, Maryland
(Town, county, and state)

10. Usual occupation Bookkeeper

11. Industry or business

FATHER 12. Name Robert Laws

13. Birthplace Cumberland, Md.

MOTHER 14. Maiden name Clara Missman

15. Birthplace Cumberland, Md.

16. Informant Registrar's Office, Clin. Records.

Address Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-18-46 (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Maryland

18. Funeral director Oder Funeral Home Inc.

Address 4644 York Road., Balto., Md.

19. 10/17 1946 (Date rec'd by registrar) Geo. Hedrick DM Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1946 at 12:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7, 1946, to October 16, 1946 and that I last saw him alive on October 16, 1946

	DURATION
Immediate cause of death: Uremia, acute	Oct. 7, 1946
Due to: Chronic Nephritis	5 Mos. plus
Due to:	
Other conditions: Hypertension, malignant Anemia, secondary	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE acn Robert M. Cullison M.D.
R. M. CULLISON, M.D. CLIN. DIRECTOR
(Medical examiner)

Address V. A. Ft. Howard, Md. Date signed 10-16-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44 097744

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 58 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 58 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1104 W. Saratoga St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME
ANDREW LEITH Alias ANDREW C. JOHNSON

3.(b) Social Security Number
213-20-4342

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Alice Leith

1-25-04 6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 4-15-1898

8. AGE: Years	Months	Days	If less than one day
48	6	7	....hrs. ....min.

9. Birthplace: Cleveland, Ohio
(Town, county, and state)

10. Usual occupation: Clergyman

11. Industry or business

FATHER
12. Name: John Leith
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Maggie Mann
15. Birthplace: ?

16. Informant: Registrar's Office, Clin. Records,
Address: Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-25-46 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: Charles R. Law
Address: 802 Madison Ave., Balto., Md.

19. Oct 25 1946 (Date rec'd by registrar) A. H. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21, 1946, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24, 1946, to October 21, 1946 and that I last saw him alive on October 21, 1946

	DURATION
Immediate cause of death: Hemorrhage from duodenal ulcer	Unknown
Due to:	
Due to:	
Other conditions: Ulcer of stomach; Chr., glomerular nephritis; tuberculosis, rt. apex; tuberculosis left adrenal (Include pregnancy within 3 months of death)	Unknown " "

Major findings of operations:

Date of op.:

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul Padget
PAUL PADGET, M. D. ACT. CLIN. DIR. M. D. or other
Address: V. A. Ft. Howard, Md. Date signed: 10-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 09774

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One day
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto.
City or town Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
Street No. 204 Hillendale Road
(If rural, give LOCATION)
2.(a) If veteran, name war WW I

3.(a) FULL NAME MARTIN E. LIDARD

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife Single
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7/23/1892

8. AGE: Years	Months	Days	If less than one day
54	2	27	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual occupation Clothes Packer
11. Industry or business

FATHER
12. Name John Edward Lidard
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden name Mary Curtis
15. Birthplace Baltimore, Maryland

16. Informant Registrar's Office, V.A.
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 24, 1946 (month) (day) (year)
Cemetery or crematory New Cathedral Cemetery
Baltimore, Maryland
Location

18. Funeral director Bernard Fink
Address 3603 Belair Rd., Balto., Md.

19. 10/22 1946 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1946, at 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 1946, to October 20 1946 and that I last saw him alive on October 20 1946

	DURATION
Immediate cause of death: Mesenteric Thrombosis	Unknown
Due to: Embolus & Mural Thrombus of left ventricle	Unknown
Due to: Coronary occlusion with infarction	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison M.D. or other
Address V.A. Ft. Howard, Md. Date signed 9-21-46
R. M. CULLISON, M.D. CLIN.DIR.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★ 09779

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
Hood Nursing Home
How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 12 Ridge Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bertha A. MacEwen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	divorced

6.(b) Name of husband or wife: Ernest H. MacEwen
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): June 12, 1878

8. AGE:

Years	Months	Days	If less than one day
68	4	13	....hrs. ....min.

9. Birthplace: Reisterstown, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: John H. Beckley
13. Birthplace: Md.

MOTHER
14. Maiden name: Christy Alder
15. Birthplace: Md.

16. Informant: John H. MacEwen
Address: Easton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/28/46 (month) (day) (year)
Cemetery or crematory: Reisterstown
Location: Reisterstown, Md.

18. Funeral director: John O. Mitchell & Sons, Inc.
Address: 1900 Eutaw Place, Baltimore-17-Md.

19. 10-26 1946 (Date rec'd by registrar) Harry D. Walker Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25, 1946, at 10:30 A M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Oct. 1 1946, to Oct 26 1946
and that I last saw h... alive on Oct 26 1946

Immediate cause of death	DURATION
(a) Arterio Sclerotic	
Cerebro Vas. Disease	6 Mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 715 Frederick Rd. Date signed 10/25

VS A15 9.45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 0078140

1. PLACE OF DEATH:
County Balto.
City or town Kingsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred: Sunshine Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Balto.
City or town Kingsville (If outside city or town limits, write RURAL and give nearest town)
Street No. Sunshine Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Pauline Maier

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Adam G. Maier
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 16th 1862

8. AGE: Years	Months	Days	If less than one day
84			..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation at home
11. Industry or business

FATHER
12. Name Fred K. Lang
13. Birthplace Germany

MOTHER
14. Maiden name Barbara Lang
15. Birthplace Germany

16. Interment Fred. G. Maier
Address Sunshine Ave Kingsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 18 46 (month) (day) (year)
Cemetery or crematory St. Paul's Luth.
Location Balto. Co. Md.

18. Funeral director Lansdale Funeral Home
Address 7401 Belair Rd.

19. 10/17/46 (Date rec'd by registrar) J. M. Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15th 1946, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 8 1945, to Oct. 15, 1946
and that I last saw h.. alive on ..... 19.....

Immediate cause of death	DURATION
Apoplexy	15 min.
Due to General Arterioscl-	?
erosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Clifford F. Hudson, Md. M. D. or other
Address Fork, Md. Date signed 10/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

09781 Reg. Diat. No. 80

1. PLACE OF DEATH:
County: Baltimore Co.
City or town: Catonsville Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 67 years
Hospital, Institution, or street address where death occurred: 601 Ingleside Avenue.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 601 Ingleside Avenue.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ernest Frederick Maisel Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Eva M. Maisel
6.(c) If alive, give age: 40 years
7. Birth date of deceased (mo., day, yr.): October 4, 1879.

8. AGE: Years: 67 | Months: — | Days: 4 | If less than one day: ...hrs. ...min.

9. Birthplace: Catonsville Maryland.
(Town, county, and state)
10. Usual occupation: Grocery Store Operator
11. Industry or business: Grocery Store

FATHER
12. Name: Christian F. Maisel
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Eleandra E. Dill
15. Birthplace: Maryland.

16. Informant: Mrs. Estle Crane
Address: 803 Edmondson Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10 | 11 | 46. (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery.
Location: Fredericks Ave, Baltimore, Md.

18. Funeral director: Easton Sons
Address: Ellicott City, Maryland.

19. 10-10 1946 (Date rec'd by registrar) Harry L. Mullin Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 OCT, 1946, at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 OCT 1946, to 8 OCT 1946
and that I last saw h... alive on Dead on arrival 19...

	DURATION
Immediate cause of death: Myocardial failure	2 days
Due to: Chronic myocarditis	Unknown
Due to: Arteriosclerosis	Unknown
Other conditions: Recent carbon monoxide exposure ? (Include pregnancy within 3 months of death)	Unknown

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stephen Lee Magness M.D.
M. D. or other
Address: 752 Frederick Ave. Date signed: 9 Oct '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09782 4 420

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5518 Delma Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles H. Wasserkrieger **(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Pattie S.
(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 20 April 1866

8. AGE: Years 80 | Months 5 | Days 23. | If less than one day ..... hrs. ..... min.

9. Birthplace Westminster, Md
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name John Wasserkrieger
13. Birthplace Maryland

MOTHER
14. Maiden name Jane Fraineck
15. Birthplace Maryland

16. Informant Mrs. Pattie S. Wasserkrieger
Address 5518 Delma Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 16 Oct 46 (month) (day) (year)
Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland
18. Funeral director F. B. Wisbert & Son
Address 1334 Eutaw Place - 17
19. 10/16 (Date rec'd by registrar) 1946 Dan Retzel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1946, at 6. P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1946 to Oct. 13 1946
and that I last saw him alive on Oct 13 1946

Immediate cause of death	DURATION
Bronchopneumonia (Tuberculous)	2 wks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Benjamin Muller M. D. or other
Address 1326 Wilkens Ave Date signed 10/17/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-a)

09783 f

CERTIFICATE OF DEATH

Reg. Dist. No. 310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Woodlawn
(If outside city or towe limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oewboro iofants give reaidooce of mother)
State: Maryland County: Baltimore
City or town: Woodlawn
(If outside city or town limits, write RURAL and give neareat towo)
Street No. 5522 Windsor Mill Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Anna Maria Mason

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Bradford J. Mason
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 15, 1873

8. AGE: Years	Months	Days	If less than one day
73	0	28	..... hrs. ..... min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Matthew Mellott
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Lucinia Deshong
15. Birthplace: Pa.

16. Informant: Mrs. Louis Ningard
Address: 55122 Windsor Mill Road

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 14, 1946 (month) (day) (year)
Cemetery or crematory: Christian Cem
Locafion: Harrisonville, Pa.

18. Funeral director: Wm. J. Tickner & Sons, Inc.
Address: North & Pennsylvania Aves.

19. 10/17/46 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13, 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 1945 to Oct 13 1946 and thef I last saw h.. alive on Oct 13 1946

Immediate cause of death	DURATION
Cerebral Cardiac Failure	2 days
Due to	
Due fo	
Other conditions Pernicious Anemia	unknown

(Include pregnancy within 3 months of death)

Major fiadiogs of operations: Date of op.
Aotopsy results:
PHYSICIAN: Please nnderlioe the caose to which death shoold be charged statistically.

22. VIOLENCE: If death was due fo external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured af home, farm, indusfry, public place (where?)
Meene of injury: Injured at work?

23. SIGNATURE: Harry Ashman M.D. M. D. or other
Address: 6 W. Centre Ave. Date signed 10/13/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

19784

Reg. Dist. No. 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Back River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Bx 395 Thompson Blvd.
How long in hospital or institution? Visitor.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 306 O. Lehigh St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Carl R. McDaniel.

3.(b) Social Security Number 202-05-2788

4. Sex: Male | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby 10 1883.

8. AGE: Years: 63 | Months: 8 | Days: 18 | If less than one day: hrs. min.

9. Birthplace: (Town, county, and state)

10. Usual occupation: Supt

11. Industry or business: Construction

FATHER 12. Name:
13. Birthplace: Unknown

MOTHER 14. Maiden name:
15. Birthplace: Unknown

16. Informant: Langenfelder & Co
Address: Pulaski Highway

17. Removal. (Burial, cremation, or removal. Which?) Date thereof 10-30-46 (month) (day) (year)

Cemetery or crematory: Moores
Location: Penna.

18. Funeral director: James J. Bugdenike
Address: 1407 Eastern Ave Rd. Essex

19. 10/29/46 A. W. Hadrill DMD Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28 1946 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 28 1946 to Oct 28 1946
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Coronary occlusion	Immediate
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. M. Carmine M.D.
Title or other
Address: Dundalk Md. Date signed: 10/29/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47d

CERTIFICATE OF DEATH

09785

Reg. Dist. No. 470

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, institution, or street address where death occurred: Vet Adm. Hospital, Ft. Howard, Maryland
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland
County: Balto
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7320 Waldman Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: SAW

3. (a) FULL NAME: JAMES G. McDONALD (James George McDonald)

3. (b) Social Security Number: none

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mrs. Mary McDonald
6.(c) If alive, give age: 67 years
7. Birth date of deceased (mo., day, yr.): 4-21-1877

8. AGE: Years	Months	Days	If less than one day
69	5	19	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Watchman, Water Dep't.
11. Industry or business: Baltimore County

FATHER
12. Name: John McDonald
13. Birthplace: Maryland

MOTHER
14. Maiden name: Levinia Norris
15. Birthplace: Baltimore, Maryland

16. Informant: Registrar's Office, Vet. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10- 14-46 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.

18. Funeral director: Henry Sander & Sons
Address: North Ave & Broadway, Balto., Md.

19. 10/12 1946 A. W. Hedrick Dr, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10, 1946 at 7:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 1946 to October 10 1946
and that I last saw him alive on October 10 1946

	DURATION
Immediate cause of death: Carcinoma of right lung with metastases to pleura mediastinum, ~~xxxx~~ liver and abdominal lymphnodes	Unknown
Due to: Unknown	
Other conditions: Hydrothorax, right	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work? ...

23. SIGNATURE: FD Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR. (M. D. or other)
Address: V.A. Ft. Howard, Md. Date signed: 10-10-46

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VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

09786

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Balto.
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 2916 Fallers Ft. Rd
How long in hospital or institution? 1 year.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2916 Fallers Ft. Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Goldie Rebecca Estelle Miller.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	Widow

6.(b) Name of husband or wife: Charles Miller.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 18, 1885

8. AGE: Years	Months	Days	If less than one day
60	11	15	..... hrs. ..... min.

9. Birthplace: Paw Paw W. Va.
(Town, county, and state)
10. Usual occupation: Nurse
11. Industry or business: Home
FATHER 12. Name: Joseph Allen Gaither
13. Birthplace: W. Va
MOTHER 14. Maiden name: Alura May Duncan
15. Birthplace: W. Va
16. Informant: Geo. W. Gaither.
Address: 2916 Fallers Ft. Dundalk Md.
17. Burial-removal (Burial, cremation, or removal. Which?) Date thereof October 5 1946 (month) (day) (year)
Cemetery or crematory: Bayard
Location: Bayard, West Virginia
18. Funeral director: Roland L. Fiehler
Address: 2112 Dundalk Ave.
19. 10/4/46 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2 1946, at 7:25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 1946, to Oct 2 1946
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Carcinoma of Breast.	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma, Breast removed. Date of op. Aug 1946
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. McCarmore M.D.
(M. D. or other)
Address: Dundalk, Md. Date signed 10/5/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09787

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 1 mo., 12 days
Hospital, institution, or street address where death occurred: Ft. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 1 mo., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2804 Frederick Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Ruby I. Muskusky

3.(b) Social Security Number: # Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph A. Muskusky
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): January 12, 1921

8. AGE: Years	Months	Days	If less than one day
25	9	9	hrs. min.

9. Birthplace: Johnstown, Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Hugh K. Arnold
13. Birthplace: Tennessee

MOTHER
14. Maiden name: Mattie Cantwell
15. Birthplace: Tennessee

16. Informant: Joseph A. Muskusky
Address: 2804 Frederick Rd., Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 24, 1946 (month) (day) (year)
Cemetery or crematory: St. John's Cemetery
Location: Ellicott City, Maryland

18. Funeral director: Easton Sons
Address: Ellicott City, Maryland

19. Oct. 21, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

Rec'd - 10-23-46 Dr. E. E. Nichols mm

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21, 1946 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 9, 1946, to October 21 1946 and that I last saw her alive on October 21, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculsosis	4 Yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation — Date of op.:
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart S Shoffer M.D. M. D. or other
Address: Mount Wilson, Md. Date signed: 10/21/46

09788

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: County Baltimore; City or town Catonsville (If outside city or town limits, write RURAL and give nearest town); How long in above place of death?; Hospital, institution, or street address where death occurred: 126 N. Symington Ave.; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State Md. County Baltimore; City or town Catonsville (If outside city or town limits, write RURAL and give nearest town); Street No. 126 N. Symington Ave. (If rural, give LOCATION); 2.(a) If veteran, name war

3. (a) FULL NAME: Ida L. Neujahr

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Married

6.(b) Name of husband or wife George G. Neujahr; 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 29, 1899.

8. AGE: Years	Months	Days	If less than one day
47	3	25	..... hrs. ..... min.

9. Birthplace Ill. (Town, county, and state)

10. Usual occupation H.W.

11. Industry or business

FATHER — 12. Name George J. Hornung; 13. Birthplace Penna.

MOTHER — 14. Maiden name Ida Diehl; 15. Birthplace Penna.

16. Informant Mr. George J. Neujahr

Address 126 N. Symington Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 28/46. (month) (day) (year)

Cemetery or crematory Lorraine Park

Location Woodlawn, Md.

18. Funeral director Harry H. Nikkel

Address 4101 Edmondson Ave.

19. 10/28 1946 A. W. Hedrick Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24/46. 19..... at 11 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1944, to October 24 1946 and that I last saw h.. alive on October 24 1946.

Immediate cause of death	DURATION
Metastatic Ca of RD. Lung	6 mo.
Due to Ca of RD. Breast.	1 yr.
Due to	
Other conditions Chr. Rheumatic Heart Disease	30 yr. (?)

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wilmer K. Gallagher M.D. M. D. or other

Address Catonsville-26, Md. Date signed 10-25-46

VS A15 9.45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13a)

CERTIFICATE OF DEATH

Reg. Dist. No. 09789

P

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Maryland

How long in hospital or institution? 28days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Talbot

City or town Bellevue (If outside city or town limits, write RURAL and give nearest town)

Street No. Bellevue (If rurol, give LOCATION)

2.(a) If veteran, name war WW I

3.(a) FULL NAME LE ROY ANDERSON NICHOLS,

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Mrs. Marie Nichols

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 2/3/1897

8. AGE: Years	Months	Days	If less than one day
49	8	26	...hrs. ...min.

9. Birthplace Broad Creek Neck, Md. (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Joseph Nichols

13. Birthplace Maryland

MOTHER 14. Maiden name Celia Grayson

15. Birthplace Baltimore, Maryland

16. Informant Registrar's Office, Clin. Records

Address Vtes. Adm. Hosp., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-31-46 (month) (day) (year)

Cemetery or crematory

Location Bellevue - Md.

18. Funeral director Charles L. Lawn

Address 802 Madison Ave.

19. 10-30 19... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 19 46, at 8:40A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 19 46, to October 29 19 46 and that I last saw h im alive on October 29 19 46

Immediate cause of death	OURATION
UREMIA	28 days
	Plus
Due to Nephrosclerosis	28 days
	Plus
Due to	
Other conditions Heart Disease - Hypertension	
Arterial - Myocardial Insufficiency (Include pregnancy within 3 months of death)	28 days Plus

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison Robert M. Cullison, M. D. Clin. Dir. M. D. or other

Address Fort Howard, Maryland Date signed 10/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

09790 Reg. Dist. No. 381

1. PLACE OF DEATH: Balto.
County
City or town: Rogers Forge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County
City or town: Rogers Forge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 422 Murdock Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Delilah C. Ohle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Philip
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Mar. 22 1856

8. AGE: Years 90 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Adams Co. Penn. (Town, county, and state)
10. Usual occupation: ---
11. Industry or business: ---

FATHER
12. Name: Aaron Wisler
13. Birthplace: Penn.

MOTHER
14. Maiden name: Harriet Bringman
15. Birthplace: Penn.

16. Informant: Miss. Alice Ohle
Address: 422 Murdock Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 16 46 (month) (day) (year)
Cemetery or crematory: Parkwood Cem.
Location: Taylor Ave.

18. Funeral director: L. Heemann and Son
Address: 32 S. Broadway

19. 10/16 1946 (Date rec'd by registrar) A to Hedrick Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13 1946 at 5.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 29 1946 to Sept. 13 1946.
and that I last saw h... alive on Sept 12 1946.

	DURATION
Immediate cause of death: Hypostatic Congestion of Lungs	2 days.
Due to: Cerebral Arteriosclerosis	—
Due to:	
Other conditions: Fracture right hip Aug 29/46. (Smith-Peterson Nail Sept 11/46)	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? Rogers Forge (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): At Home
Means of injury: Tripped on Rug Injured at work?

23. SIGNATURE: Henry B. Athey M.D. M. D. or other
Address: 2504 St Paul St. Date signed Oct. 14/46.

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-71)

CERTIFICATE OF DEATH

09791

Reg. Dist. No. 43

1. PLACE OF DEATH:
County: Baltimore
City or town: Baltimore #6
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: ~~#6~~ Bayside and
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Balto #6 Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 115 Leslie Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward H. Orn

3.(b) Social Security Number: 246-07-9575

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ethel M. Orn
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 10th 1893

8. AGE: Years	Months	Days	If less than one day
53	6		..... hrs. ..... min.

9. Birthplace: Connecticut (Town, county, and state)
10. Usual occupation: electrician
11. Industry or business

FATHER
12. Name: ——
13. Birthplace ——

MOTHER
14. Maiden name ——
15. Birthplace ——

16. Informant: Mrs. E.W. Orn
Address 115 Leslie Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 (month) 19 (day) 46 (year)
Cemetery or crematory: Parkwood
Location: Balto. Md.

18. Funeral director: Loeahner Funeral Home
Address 7401 Belair Rd.

19. Oct. 17 1946 (Date rec'd by registrar) Mrs. E. L. Rupp Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death — DURATION

Carbon Monoxide Gas
Due to from Automobile
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
~~Accident~~, suicide, ~~or homicide~~ Suicide Date of 10/15/46
Where did injury occur? Parkton (City or town) Balto (County) Md (State)
Injured at home, farm, industry, public place (where?) Public Place
Means of injury Gas from Auto Injured at work? No

23. SIGNATURE: Wm. Garnine M.D.
M.D. or other
Deputy Medical Examiner
Address Towson Md Date signed 10/16/46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(5)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09792 301
Reg. Diat. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore-18
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1802 Chilton Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Selina O'Toole

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Joseph O'Toole
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 26, 1868

8. AGE: Years	Months	Days	If less than one day
78	6	8	hrs. min.

9. Birthplace: Australia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: William Turner
13. Birthplace: Ireland
MOTHER 14. Maiden name: Elizabeth -
15. Birthplace: Ireland
16. Informant: Hospital records
Address: Catonsville-28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 28, 1946 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Baltimore Md.
18. Funeral director: Thomas J. Kenny Inc
Address: Hollins & Gilmor Sts.
19. 10/28 (Date rec'd by registrar) 1946 A.W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24- 1946, at 9:40 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 4 1946, to October 24 1946 and that I last saw her alive on October 24 1946

Immediate cause of death	DURATION
Chronic myocardial insufficiency	--indef.
Due to Chronic hypertensive cardio-vascular disease	--indef.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other
Address: Catonsville-28, Md. Date signed: 10-24-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09793 4

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred: 7 Ridge Road, Edmondson Ridge
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7 Ridge Road - Edmondson (If rural, give LOCATION) Ridge
2.(a) If veteran, name war

3.(a) FULL NAME Frank Timothy Parr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Marie P. Parr
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 11, 1888

8. AGE: Years	Months	Days	If less than one day
58	3	7	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Fire Ins. Underwriter
11. Industry or business: Geo. C. Swope & Co.
FATHER 12. Name: Henry Parr
FATHER 13. Birthplace: Md.
MOTHER 14. Maiden name: Louise Ulbrich
MOTHER 15. Birthplace: Md.
16. Informant: Mrs. Marie P. Parr
Address: 7 Ridge Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 21/46. (month) (day) (year)
Cemetery or crematory: Loudon Pk.
Location: 3801 Frederick Road.
18. Funeral director: Harry H. Tuttle
Address: 401 E. Edmondson ave
19. 10/18 19 46 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 18/46. 19..... at 3-15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 19 46 to Oct 18 19 46
and that I last saw h... alive on Oct 18 19 46

Immediate cause of death	DURATION
Coronary Thrombosis	4 days
Due to: Myocarditis	6 mo.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Geo. C. Ulbrich M. D. or other
Address: Catonsville 28 Md. Date signed 10.18.46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

803 Frederick Rd.
Ellicott City

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

09794

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution? 15 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 511 Hollen Road
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: WARREN W. PEARMAN

3.(b) Social Security Number: 215-10-9974

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Myrtle Pearman

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): 3-3-95

8. AGE:

Years	Months	Days	If less than one day
51	7	15	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Retired (Insurance Inspector)

11. Industry or business: Sun Life of America Ins. Co.

FATHER
12. Name: James A Pearman
13. Birthplace: Virginia

MOTHER
14. Maiden name: Laura Joyce
15. Birthplace: Maryland

16. Informant: Registrar's Office, Vets. Adm. Hosp.
Address: Ft. Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: OCT., 22, 1946 (month) (day) (year)

Cemetery or crematory: Parkwood Cemetery

Location: Baltimore, Maryland

18. Funeral director: Wm. J. Tickner & Sons

Address: North & Penn. aves., Balto., Md.

19. 10/21/46 (Date rec'd by registrar) 19.... A. W. Hedrick Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18, 1946 at 12:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3, 1946, to October 18, 1946 and that I last saw him alive on October 18, 1946

Immediate cause of death	DURATION
CHRONIC GLOMERULAR NEUPHRITIS	20 yrs.
Due to	
Due to	
Other conditions: Hypertension; Hypertrophy of Heart. Coronary Arteriosclerosis	20 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: SUBSTANTIATED AS ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. C. Newman, M. D.
M. D. or other

Address: V.A. Fort Howard, Md. Date signed: 10-18-46

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ 09795

Reg. Diat. No. 40

1. PLACE OF DEATH:
County: Balto
City or town: Glen Arm (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr - 3 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Glen Arm (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Maude C Pettiford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C.	Widowed

6.(b) Name of husband or wife: Harvey Pettiford
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 14 1895

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
51	4	15		

9. Birthplace: Virginia (town, county, and state)
10. Usual occupation: House wife
11. Industry or business: —

FATHER
12. Name: Henry Custer
13. Birthplace: Virginia

MOTHER
14. Maiden name: Ella Hopkins
15. Birthplace: Virginia

16. Informant: Mrs Eudora Tanner
Address: Glen Arm, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof, Nov 1 (month) 2 (day) 46 (year)
Cemetery or crematory: Mt Zion Cem
Location: Long Green Md

18. Funeral director: Chas E Gosso
Address: Benson, Md

19. 11/1/46 (Date rec'd by registrar) 19__ Registrar: W M Simmons

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29 1946 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Coroners Case 19__ to 19__
and that I last saw h__ alive on 19__

Immediate cause of death	DURATION
Coronary Occlusion	2 yrs.
Due to: Arterio-Sclerosis	mth.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John L. Green M. D.
Address: Baltimore Co. Md. M. D. or other
Date signed: 10/29/46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

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Dr. Alessi

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-0)

CERTIFICATE OF DEATH

09796 8

Reg. Dist. No. 40 0

1. PLACE OF DEATH:
County: Baltimore Cub-Hill
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Cub Hill, R.F.D.#6- Route #4
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cub-Hill
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cub Hill, R.F.D. #6, Route#4
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Daisy Irene Posey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Joseph S. Posey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1884

8. AGE: Years	Months	Days	If less than one day
62	7	25	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: at home
11. Industry or business
FATHER 12. Name: Brice B. Du Val
13. Birthplace: Md.
MOTHER 14. Maiden name: Janie C. ?
15. Birthplace: Md.
16. Informant: Mr. Joseph S. Posey
Address: Cub-Hill, R.F.D.6 Route 4
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/24/46 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Baltimore County
18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Road-14-
19. 10/22 (Date rec'd by registrar) 19 46 A W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21st, 19 46, at 405 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14 19 35, to Oct 21 19 46 and that I last saw h[illegible]ative on Oct 21 19 46

Immediate cause of death	DURATION
Coronary thrombosis	15 min
Arteriosclerotic cardiovascular disease	10 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Alessi M D
Address: 6217 Harford Rd M. D. or other
Date signed: 10/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1M

09797

STATE OF MARYLAND—CERTIFICATE OF DEATH

83-a

1. PLACE OF DEATH

County Baltimore Registration Dist. No. 30

Village or City Catonsville-House-in-Pines No. Fusting Ave. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Carrie Long Price If U. S. Veteran, specify WAR Worcester

(a) Residence: No. St., Ward. Snow Hill, ~~Somerset~~ Co., Md.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	white	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James S. Price

6. DATE OF BIRTH (month, day, and year) June 25, 1867

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	3	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Somerset County, (State or country) Md.

FATHER

13. NAME Edwin Miles Long

14. BIRTHPLACE (city or town) Somerset County (State or country) Md.

MOTHER

15. MAIDEN NAME Emily Hawkes

16. BIRTHPLACE (city or town) Vermont (State or country)

17. INFORMANT Jay S. Price

(Address) Garrison Rd., Owings Mills, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Snow Hill, Md. Date 10/22/46, 19

19. UNDERTAKER John O. Mitchell & Sons, Inc.

(Address) 1900 Eutaw Place, Balto., Md.

20. FILED 10-21, 1946 Harry D. Mullo Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October 19 (Month) (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from October 14, 1946 to October 19, 1946

I last saw her alive on October 19, 1946; death is said to have occurred on the date stated above, at 8:00 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	10/14/46
Other Contributory Causes of importance: Generalized Arteriosclerosis	?

Name of operation Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No.

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify

(Signed) Wilmer K. Gallagher M. D.

(Address) Catonsville-28, Md.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

Addition of Inst. by phone to Sam 11-12-46 ems

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

09798

Reg. Dist. No. 472

1. PLACE OF DEATH:
County: Balto
City or town: Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Brook R Crossing Sulphur Spg Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3100 Sulphur Spg Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Viola L Roy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 23. 1909

8. AGE:

Years	Months	Days	If less than one day
36	10	22	hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business
FATHER — 12. Name: Jotham B Ryder
13. Birthplace: Md
MOTHER — 14. Maiden name: Mary Harbaugh
15. Birthplace: Pa
16. Informant: Fran W Ohler
Address: 3100 Sulphur Spg Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-14-46 (month) (day) (year)
Cemetery or crematory: Gettysburg
Location:
18. Funeral director: Edw Tonlson
Address: 2359 Wash Blvd
19. Oct 13 46 (Date rec'd by registrar) G. Kieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 13 46 abt 6 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Multiple fractures — DURATION
Due to: Legs, arms & face
Due to: Abdomen torn open
Other conditions: accident
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of Oct 13. 46
Where did injury occur? Lansdowne Balto Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Public place
Means of injury: Struck by Locomotive Injured at work? no

23. SIGNATURE: G. W. Kieffer M. D. or other Address: 1010 Leadenhall Date signed: 10-13-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09799

CERTIFICATE OF DEATH

Reg. Dist. No. 38-1

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, institution, or street address where death occurred:
105 La Tair Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 105 La Tair Lane
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME Harry Edgar Reddish

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Helen
8.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): August 23, 1876
8. AGE: Years 70 | Months 2 | Days 4 | If less than one day ..... hrs. ..... min.
9. Birthplace: Baltimore (Town, county, and state) Md
10. Usual occupation: Supervisor Motion Picture
11. Industry or business: F A Darked
12. Father — Name: Thomas Reddish
13. Father — Birthplace: Md
14. Mother — Maiden name: Unknown Hudson
15. Mother — Birthplace: Md
16. Informant: Gilbert M. Reddish
Address 5207 Walther Blvd
17. Burial, cremation, or removal. Which?: Burial Date thereof 10/30/46 (month) (day) (year)
Cemetery or crematory: Green Mount
Location: Baltimore Md
18. Funeral director: Milburn Cole Son
Address 1904 Pont St
19. 10/29 1946 (Date rec'd by registrar) H. L. Hetherington M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 27 1946, at 4:15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943, to Oct 27 1946
and that I last saw h.im alive on October 26 1946

Immediate cause of death	DURATION
Coronary Sclerosis	Years
Due to Arteria Sclerotic Heart Disease	Years
Due to Arteria Sclerosis generalized	Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Henry L. Hetherington M. D. or other
Address 20 E. Preston St Date signed 10/29/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Maryland State

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 42 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
(a) ~~Baltimore City~~ Maryland 13th Prec. ~~County~~, Maryland Arbutus
(b) Street address 1323 Stevens Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1323 Stevens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Elizabeth Renshaw

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or wife: Frederick Renshaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15th 1879

8. AGE: Years 66 | Months 9 | Days 28 | If less than one day: hr. min.

9. Birthplace Taneytown Md.
(Town, county, and state)

10. Usual Occupation At Home
11. Industry or business Housewife

FATHER
12. Name George W. Heath
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ann Robertson
15. Birthplace Md.

16 (a) Informant Frederick Renshaw
(b) Address 1323 Stevens Ave - Arbutus

17 (a) Burial (b) Date thereof 10/16/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oak Grove
Location Taneytown Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St.

19 (a) 10/14/46 (b) Alw. Hedrick M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1946, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1946, to October 13 1946, and that I last saw her alive on October 11, 1946.

Immediate cause of death Uremia — Duration 15 days

Due to Arteriosclerotic Cardio-Renal Degenerative Disease — ?

Due to

Other Conditions Infectious Arthritis — Jan 1946
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Pearl Ross, M.D.

Address 4001 Wilkens Ave Date signed 10-13-46
M. D.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Edmondson Ave & Spunney Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie M Ripple

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W.

6.(b) Name of husband or wife: John W
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1858?

8. AGE: Years: 88 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: Henry Leadenes
13. Birthplace: Maryland

MOTHER
14. Maiden name: Not Known
15. Birthplace: " "

16. Informant: Mrs Edwin J Murphy
Address: 103 Forrest Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-23-46 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: Baltimore Md
18. Funeral director: George A Fuhrey
Address: Fulton Ave & Fayette

19. 10-22-1946 (Date rec'd by registrar) Harry L Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-19-1946 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/1 1945, to 10-21 1946
and that I last saw h alive on 1946

Immediate cause of death	DURATION
Bronchopneumonia	3 days
Due to	
Due to	
Other conditions Chronic Myocarditis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Alden H Emerton M. D. or other
Address: 4709 Hudson Ave Date signed: 10-21-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
OCT 24 1946

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09802

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years, 1 month, 24 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 6 years, 1 month, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 506 Collins Avenue (If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Katherine Kaiserski Rohe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	married

6.(b) Name of husband or wife: Daniel Alfonsus Rohe

6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): May 6, 1893

8. AGE:	Years	Months	Days	If less than one day
	53	5	21	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER

12. Name: John Kaiserski

13. Birthplace: Poland

MOTHER

14. Maiden name: Julia Wicher

15. Birthplace: Albany, New York

16. Informant: Hospital Records

Address: Baltimore 28, Md. (Catonsville)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/30/46 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: 3900 Old Frederick Rd

18. Funeral director: Harry H. Witzke

Address: 4101 Edmondson Ave

19. 10-29-46 (Date rec'd by registrar) [illegible] Registrar

1-35 7

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 1946, at 5:35 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19...., to .... 19....

and that I last saw h.... alive on .... 19....

	DURATION
Immediate cause of death: Circulatory Collapse	
Due to:	
Due to: Broncho Pneumonia	
Other conditions: sudden death inquiry	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo. S. McKieffer Asst Med Exam of Balto M. D. or other

Address: 1010 Leeds Ave Date signed: Oct 28 46

MARYLAND STATE DEPARTMENT OF HEALTH

09803 P

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Diat. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto.
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Augsburg Home - Campfield Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3306 Shellburne Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CATHARINE D. SCHIMPF

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

B.(b) Name of husband or wife: --

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 19, 1856

8. AGE: Years	Months	Days	If less than one day
90	1	4	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: School Teacher

11. Industry or business: Retired

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Records of Augsburg Home
Address: Campfield Rd., Balto. Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/25/46 (month) (day) (year)
Cemetery or crematory: St. Pauls Cem.
Location: Violetville, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 10/24/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23, 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 20 1946, to Oct. 23 1946 and that I last saw h.e.r. alive on Oct. 20 1946

Immediate cause of death	DURATION
1) - Cerebral - Sclerosis	
Heart Disease	- 5 yrs?
Due to	
Due to - Senescence - Cerebral - Sclerosis -	10 yrs
Other conditions - None	

(Include pregnancy within 3 months of death)

Major findings of operations: - None - Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Earl L. Chambers M.D. M. D. or other
Address: 4108 Liberty Hts. Ave. Date signed: 10/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Diat. No. 09804 44

1. PLACE OF DEATH:
County Baltimore
City or town Lynch Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Lynch Point (Balto. City 19)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3004 Ritchie Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Andrew J. Seckens-Dzmura
3.(b) Social Security Number 213-09-3368

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Louise H. Seckens-Dzmura (nee McDonald)
6.(c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): January 18, 1895

8. AGE: Years 51 | Months 9 | Days | If less than one day ... hrs. ... min.

9. Birthplace: Pittsburg, Pa. (Town, county, and state)
10. Usual occupation: Furnace attendant in Pipe Mill
11. Industry or business: Bethlehem Steel Corp. (Sparrows Pt.)
FATHER 12. Name: Basil Seckens
13. Birthplace: Bohemia
MOTHER 14. Maiden name: Mary Patenska
15. Birthplace: Bohemia
16. Informant: Mrs. Louise H. Seckens-Dzmura (wife)
Address: 3004 Ritchie Ave; Lynch Pt; Balto. City 19, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 21, 1946 (month) (day) (year)
Cemetery or crematory: Oakdown Cemetery
Location: Baltimore County, Md.
18. Funeral director: J. Coyard Evans
Address: 1400 E. Biddle St, Balto. 30, Md.
19. Oct 19 1946 (Date rec'd by registrar) Dawson L. Harbes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17, 1946 at 3:20 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1946 to Oct 18- 1946
and that I last saw him alive on Oct 17th 1946
Immediate cause of death: Carcinoma of Sigmoid with metastasis to Abdominal Lymphnodes — Duration: 8 mos?
Due to: Cardiac failure — Duration: 2 days
Other conditions: none
(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma of Sigmoid
Colostomy — Date of op. July 1946
Autopsy results: (No)
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Dawson L. Harbes M. D. or other
Address Sparrows Point, Md. Date signed Oct 19 1946

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Skiorsky
1500 N. Ellwood Avenue

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

09805 P

Reg. Dist. No. 440

1. PLACE OF DEATH:
County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Philadelphia & Chesaco Avenue
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. Philadelphia & Chesco Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Annie S. Seling

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife Christopher F. Seling
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1852

8. AGE: Years	Months	Days	If less than one day
93	11	23	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation at home
11. Industry or business
FATHER 12. Name John Kimmell
13. Birthplace Germany
MOTHER 14. Maiden name Magdelena ?
15. Birthplace Germany
16. Informant Mr. A. Seling,
Address
17. Burial Date thereof 10/9/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Baltimore
18. Funeral director Leonard J. Ruck
Address 5305 Harford Road -14-
19. 10-7 19 46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6th, 19 46, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 46, to Oct 6 19 46, and that I last saw h alive on Oct 5 19 46

Immediate cause of death	DURATION
Acute Cardiac Failure	2
Due to	
Due to	
Other conditions Bronchial Pneumonia	4 Days

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Albert L. Skiorsky M. D. or other
Address 29-9 Ellwood Ave Date signed 10/7/46

VS A15 9-45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

★ 09806 38

1. PLACE OF DEATH (93d)

County Baltimore Registration Dist. No.

Village or City Towson No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Hetty W. Shearman

(a) Residence: No. 512 Paula Ave St., Ward.

(Usual place of abode) If nonresident give city or town and State

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V.S. No. 1

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F.	W.	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Marion Shearman

6. DATE OF BIRTH (month, day, and year) July 22, 1853

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
93	3	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Homemaker

9. Industry or business in which work wes done, es SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupetion (month end year)

11. Totel time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore, Maryland (State or country)

FATHER

13. NAME David Noyes

14. BIRTHPLACE (city or town) England (State or country)

MOTHER

15. MAIDEN NAME Mary Pyper

16. BIRTHPLACE (city or town) England (Stete or country)

17. INFORMANT M. B. Shearman (Address)

18. BURIAL, CREMATION, OR REMOVAL Place Waugh Chapel Date Oct. 30, 1946

19. UNDERTAKER Landon & Brooks Inc. (Address) Towson, Md.

20. FILED Oct 29, 1946 [signature] Deputy Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October (Month) 28 (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attendad deceased from July, 1936, to 28 Oct, 1946

I last saw h...er alive on 28 Oct., 1946; death is said to have occurred on the date stated above, at 8 P. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Myocardial Degeneration	14 Oct 46
Other **Contributory Causes** of importance: Arteriosclerotic Cardio Vascular disease	1936

Name of operation Data of

Whet test confirmed diagnosis? Was there an autopsy? No

23. If death was dua to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Whera did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disaase or injury in any wey related to occupation of deceased? No

If so, specify

(Signed) C. Charles Jr. Teer M. D.

(Address) 6701 York Rd Baltimore Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

M

MARGIN RESERVED FOR BINDING

I

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (50)

Reg. Dist. No. 38 1 P

CERTIFICATE OF DEATH

69807

1. PLACE OF DEATH:
(a) County Balto.
(b) City or town Ruxton
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County
(c) City or town Ruxton
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Vera Smick

3 (b) If veteran, name war —

3 (c) Social Security No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ Henry Smick

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29th 1865

8. AGE: Years 81 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Hicks
13. Birthplace N.C.

MOTHER 14. Maiden Name Martha Burke
15. Birthplace N.C.

16 (a) Informant Mrs. Alma Thumel
(b) Address Ruxton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) 10/7/46 (Date rec'd by registrar) (b) A. W. Hedrick Registrar

DS

1-25-380-10

MEDICAL CERTIFICATION

20. Date of death Oct. 5 1946, at 1:20 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 44 1944, to Oct 4 1946.
and that I last saw him alive on Oct 4 1946.

Immediate cause of death	Duration
Carcinoma (breast)	2 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A Gullett M.D.
M. D. or other
Address Towson Md Date signed 10/5/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

Reg. Diat. No. 09809 31 0

1. PLACE OF DEATH:

County: Balto.

City or town: Hebbville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred: Mayfield Ave.

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Hebbville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mayfield Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: WALTER J. SMITH

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Charlotte V. Smith

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 31, 1885

8. AGE: Years	Months	Days	If less than one day
61	6	6	hrs. min.

9. Birthplace: Wilmington, Del. (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: Walter M. Smith

13. Birthplace: Wilmington, Del.

MOTHER — 14. Maiden name: Florence M. -

15. Birthplace: Wilmington, Del.

16. Informant: Mr. William G. Smith

Address: 1327 Linden Ave., Arbutus

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10/10/46 (month) (day) (year)

Cemetery or crematory: Montrose

Location: Upper Darby, Phila., Pa.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 10/9/46 (Date received by registrar) 19 A. W. Hedrick Registrar

1-35

98

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 7, 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10 1946, to Oct 7 1946, and that I last saw h in alive on Oct 7 1946.

	DURATION
Immediate cause of death: cardiac Asthma	3da
Due to: Carcinoma of Liver	1 mo.
Due to: Ascites	1 week
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. W. Toom M. D. or other

Address: 1202 S. 46 Land St. Date signed: 10/7/46

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 0980 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Balto
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 hrs
Hospital, institution, or street address where death occurred: Spring Grove State Hosp
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County:
City or town: Balto (If outside city or town limits, write RURAL and give nearest town)
Street No. 2653 Frederick ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Germaine Mary Smithers
3.(b) Social Security Number

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Boyd G Smithers
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Mch 17, 1901

8. AGE: Years 45 Months 6 Days 24 If less than one day ... hrs. ... min.

9. Birthplace: Balto (Town, county, and state)
10. Usual occupation: Home duties
11. Industry or business
FATHER 12. Name: Henry Weiber
13. Birthplace: NY
MOTHER 14. Maiden name: Lena ~~Dieter~~ Dinges
15. Birthplace: Md
16. Informant: Record
Address: Spring Grove State Hosp.
17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof: 10/14/46 (month) (day) (year)
Cemetery ~~or crematory~~: Cathedral
Location: Balto. Md.
18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St Balto 2 Md.
19. 10/12 1946 Alex. Hedian DR Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1946 at 3 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...
and that I last saw h... alive on ... 19 ...

	DURATION
Immediate cause of death: Hypostatic Pneumonia	
Due to	
Due to: Cardio vascular disease	
Other conditions: sudden death Injury	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Geo M Kieffer Asst Med Exam Balto M. D. or other
Address: 1010 Leeds Ave Date signed 10-11-46

VS A15 9-45

I

1-33

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (78-2)

CERTIFICATE OF DEATH

Reg. Diat. No. 0981301

P

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Catonsville Nursing Home, 315 Ingleside Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 315 Ingleside Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward O. H. Spamer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife: Amelia H. Spamer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 10, 1867.

8. AGE: Years	Months	Days	If less than one day
79	6	23	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Spamer
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mr. P. August Grill
Address: 613 Rosedale St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 7/46. (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: 3801 Frederick Rd.
18. Funeral director: Harry H. Mitchell.
Address: 4101 Edmondson Ave.

19. 10/7/46 19..... A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 3/46. 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15 1946, to Oct 3 1946 and that I last saw him alive on Oct 3 1946

Immediate cause of death	DURATION
Chronic cardiovascular disease	?
Due to: Arteriosclerosis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Jean O. Kirkman, M.D. M. D. or other
Address: Edmondson Rd. Date signed 10/5/46

98

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

09812 44
Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Middleborough
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Middleborough
(If outside city or town limits, write RURAL and give nearest town)
Street No. Box 301 Nanticoke Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Kenneth L. Spence Sr.

3.(b) Social Security Number 214-03-6387

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Emelia Spence
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 7, 1884

8. AGE: Years	Months	Days	If less than one day
62	3	3	..... hrs. ..... min.

9. Birthplace Md.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business Standard Oil Co.
FATHER 12. Name John Spence
13. Birthplace Md.
MOTHER 14. Maiden name Unknown
15. Birthplace
18. Informant George Spence
Address Box 301 Nanticoke Rd. Middleborough
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 14, 1946 (month) (day) (year)
Cemetery or crematory Mt. Carmel Cem.
Location Balto. Md.
18. Funeral director Philip Hewig Sons
Address 2024 Orleans St.
19. Oct. 11 1946 (Date rec'd by registrar) John L. Cornell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1946 at 8:59 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1942 to Oct. 10 1946
and that I last saw h... alive on October 9 1946

	DURATION
Immediate cause of death Coronary Occlusion	15 min.
Due to arteriosclerosis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John C. Baier M.D.
M. D. or other
Address 815 Eastern Ave Balto 21 Date signed Oct 10/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-C)

CERTIFICATE OF DEATH

★09813 Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Baltimore
City or town: Fullerton P O Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
East Joppa Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: As in No 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SRAVER Henry W. Sraver

3.(b) Social Security Number: 212-16-8124

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha H Sraver
Dec 21 1883
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 21 1883

8. AGE:

Years	Months	Days	If less than one day
62	10	1	hrs. min.

9. Birthplace: Baltimore County Md (Town, county, and state)
10. Usual occupation: Truck Farmer
11. Industry or business:

FATHER
12. Name: Wilhelm Sraver
13. Birthplace: Baltimore City Md

MOTHER
14. Maiden name: Katherine Shipley
15. Birthplace: Baltimore City Md

16. Informant: Mrs Henry W Sraver
Address: E Joppa Road Fullerton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/24/46 (month) (day) (year)
Cemetery or crematory: Zion Lutheran
Location: Stemmers Run Md
18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Rd Balto 6 Md
19. 10/23/46 (Date rec'd by registrar) 19 H M Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 22nd 1946, at 12:5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1945, to Oct 22 1946 and that I last saw him alive on Oct 22 1946.

	DURATION
Immediate cause of death: Toxemia	1 yr
Due to: Carcinoma of Tongue	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo M. Baumgardner M. D. or other
Address: Balto 6 Md Date signed: 10-22-46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (183)

Registered No. [redacted] 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1. PLACE OF DEATH:
(a) Baltimore ~~City~~ Maryland
(b) Street address 418 Eastern ave - Essex, Md
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 09810
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 Cambridge Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME Joseph Srebrowski 02 SREBROSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-6260

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 65 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs Alexandria Srebroski
(b) Address 2120 Cambridge st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location AA COUNTY - BROOKLYN

18 (a) Funeral director George A Weber
(b) Address 705 S Ann St

19 (a) (Date received by registrar) OCT 30 1946 (b) A.W. Hedrick (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28-1946, at 5 P.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Found drowned, October 26, 1946, in Little Gunpowder Creek, Md.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 10-29-46

09814

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 189 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
How long in hospital or institution? 189 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wash.
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 60 West North Street
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I

3.(a) FULL NAME JEROME S. STEWART

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	Widowed

6.(b) Name of husband or wife Widowed
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5-25-92

8. AGE: Years	Months	Days	If less than one day
54	4	23	..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Unemployed
11. Industry or business
FATHER 12. Name Russell Stewart
13. Birthplace Virginia
MOTHER 14. Maiden name Ida Dixon
15. Birthplace Virginia
16. Informant Registrar's Office, Clin. Records
Address Vets. Adm. Hosp., Ft. Howard, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-22-46 (month) (day) (year)
Cemetery or crematory Baltimore National
Location Baltimore, Md.
18. Funeral director Charles K. Laws
Address 802 Madison Ave.
19. 10/21/46 (Date rec'd by registrar) 19..... A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1946 at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12, 1946, to October 18, 1946 and that I last saw him alive on October 18, 1946

Immediate cause of death	DURATION
Squamous cell carcinoma of penis with wide spread infiltration into xxx tissue surrounding inguinal nodes	2 yrs.
Due to	
Other conditions Cachexia	6 months

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE R.L. Robert M. Cullison M. D. or other
R. M. CULLISON, M.D. CLIN. DIRECTOR
Address VAH FT. HOWARD, MD. Date signed 10-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (5th)

09815

CERTIFICATE OF DEATH

Reg. Diat. No. 43

1. PLACE OF DEATH:
County Baltimore
City or town Chesaco Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 10 yrs -
Hospital, Institution, or street address where death occurred:
—
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Baltimore
City or town Chesaco Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 403 Patapsco Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME Joseph Sudbrak

3.(b) Social Security Number —

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Elizabeth M. Davey Sudbrak
6.(c) If alive, give age: 53 years
7. Birth date of deceased (mo., day, yr.): May 8th, 1892

8. AGE: Years 54 | Months 5 | Days 4 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Hauling Contractor
11. Industry or business: Own — (Trucking)

FATHER
12. Name: Henry Sudbrak
13. Birthplace: Germany

MOTHER
14. Maiden name: Annie Eicks
15. Birthplace: Germany

16. Informant: Mrs. Elizabeth M. Sudbrak (wife)
Address: 403 Patapsco Ave., Chesaco Pk., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 15 1946 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem.
Location: Baltimore, Md.

18. Funeral director: J. Everhard Evans
Address: 1400 E. Chas. St. Balto. 30, Md.

19. (Date rec'd by registrar) 10/17 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12th 1946 at 1:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15- 1945 to Oct 12th 1946 and that I last saw him alive on Oct 11- 1946

Immediate cause of death: Uraemia — DURATION: 3 days
Due to: Carcinoma of Penis — 1 1/2 yrs.
Due to: —
Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of penis — Date of op: Jan 14, 1946
Autopsy results: Exam't refused
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: M. M. McDermott M. D. or other
Address: 1136 Poplar Grove St. Date signed: 10/13/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9.30-10P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

09816

CERTIFICATE OF DEATH

Reg. Diat. No. 34

1. PLACE OF DEATH

County Baltimore

City or town Beachleysville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Beachleysville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Nora E Talbott

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W.

6.(b) Name of husband or wife Frank V Talbott

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17 - 1877

8. AGE: Years	Months	Days	If less than one day
69	2	9	hrs. min.

9. Birthplace Maryland (Town, county and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Charles W Gore

13. Birthplace Maryland

MOTHER 14. Maiden name Mary D. L. Shaver

15. Birthplace Maryland

16. Informant Spencer Gore

Address Parkton. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 29/46 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Balto. Md

18. Funeral director Edw C Tipton

Address Hampstead Md

19. Oct 26 1946 Cyril E. Fowble M.D. Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26, 1946, at 2 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Apr. 1, 1946, Oct. 26, 1946

and that I last saw h. W alive on Oct. 23, 1946

Immediate cause of death	DURATION
Gangrene of foot	
Due to Gen. Arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edw M. Bush M. D. or other

Address Hampstead Md Date signed 10/29/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
OCT 29 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 098130

1. PLACE OF DEATH:

County: Baltimore

City or town: catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: maryland County: Balto

City or town: catonsville (If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Shadynook Lane (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William J. Teipe Jr

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife: Helen Buskirk

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): Nov 17. ~~1945~~ 1875

8. AGE: Years	Months	Days	If less than one day
50	11	20	hrs. min.

9. Birthplace: Balto Co, (Town, county, and state)

10. Usual occupation: Int Revenue Depart.

11. Industry or business

FATHER 12. Name: Wm. J. Teipe

13. Birthplace: balto. co,

MOTHER 14. Maiden name: Wilhelmina Heffmah

15. Birthplace: Balto Co

16. Informant: Austin W. Teipe

Address: Shady nook Ave. & Frederick road

17. burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2. 1946 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemy.

Location: 3801 Frederick Ave.

18. Funeral director: John O Mitchell & Sons Inc.

Address: 1900 Eutaw Place

19. 11-1 1946 Harry L. Miller Deputy Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 1946, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to Cardio vascular disease	
Other conditions sudden death	
(Include pregnancy within 3 months of death) injury	

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Geo Watkins for Evan J Ball M. D. or other Asst Med Exam

Address: 1010 Leads Ave. Date signed Oct 31 46

VS A15 9-45-10M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1646)

CERTIFICATE OF DEATH

★ 09818

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Middle River - 20
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1925 Leland ave (LELAND AVE)
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Elizabeth Todd.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widow.

6.(b) Name of husband or wife: Thomas W. Todd
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan 26 1881

8. AGE: Years: 65 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Karl H. Kuechle
13. Birthplace: Germany

MOTHER
14. Maiden name: Helene Kress
15. Birthplace: Germany

16. Informant: Mrs. Geo B. King
Address: 1925 Leland Ave, Middle River

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 14 46 (month) (day) (year)

Cemetery or crematory: Western Cem
Location: Balto Md

18. Funeral director: Philip Herwig Sons
Address: 2024 Orleans St.

19. Oct. 24 1946 (Date rec'd by registrar) John G. Connelly (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-22-46 19..... at 7:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19....., to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pulmonary Embolism	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of 10-22-46
Where did injury occur? ..... (City or town) ..... (County) ..... (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: W. D. Davis M.D.
M. D. or other
Address: Baltimore Md Date signed: 10-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1576

CERTIFICATE OF DEATH

09819

Reg. Diat. No. 39

1. PLACE OF DEATH:

County: Baltimore

City or town: Phoenix Jarrettsville Pike
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One week

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Phoenix (Twp.) Middle River suburban
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5510 Seversky Court Baltimore 21
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Stanley Faison Trapp

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife: —

7. Birth date of deceased (mo., day, yr.): Sept 10, 1946

6.(c) If alive, give age: 3 wks years

8. AGE:

Years	Months	Days	If less than one day
		22	hrs. min.

9. Birthplace: Middle River, Baltimore County, Md.
(Town, county, and state)

10. Usual occupation: Infant (Bon Secours Hospital)

11. Industry or business

FATHER
12. Name: Stanley Herman Trapp
13. Birthplace: Phoenix, Md.

MOTHER
14. Maiden name: Elizabeth Faison
15. Birthplace: Charlotte, N.C.

16. Informant: Father: Stanley H. Trapp
Address: Phoenix, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 3, 1946 (month) (day) (year)

Cemetery or crematory: St. John's Lutheran

Location: Blenheim, Balto. Co., Md.

18. Funeral director: John Burns Sons

Address: Towson, Md.

19. Oct. 3 1946 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2 1946, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death: Spina bifida, congenital, thoracic spine, with decubitus and Malnutrition — DURATION: 22 hrs 10 days

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Rollin L. Hudson M.D., D.M.E.
M. D. or other

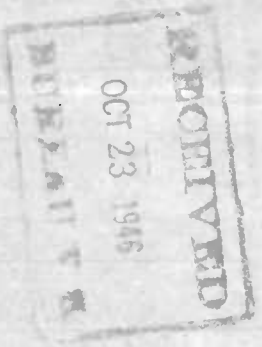
Address: Towson Md Date signed 10/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Mrs. Anna Pearce Price
Speaks



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

10452

Reg. Diat. No. 44

1. PLACE OF DEATH:
County Maryland — Balto.
City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland
How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 Madison Street
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I

3.(a) FULL NAME MORRIS McHENRY TROTT

3.(b) Social Security Number 212-16-6963

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife Divorced

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-16-1894

8. AGE: Years	Months	Days	If less than one day
52	5	7	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Elliott Trott
13. Birthplace Maryland

MOTHER 14. Maiden name Rosa Belle Crutchly
15. Birthplace Maryland

16. Informant Registrar's Office, Clin. Records
Address Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 25-46 (month) (day) (year)
Cemetery or crematory Annapolis National Cemetery
Location Annapolis, Maryland

18. Funeral director John A. Miller
Address 2334 Jefferson St., Balto., Md.

19. Oct 23 1946 (Date rec'd by registrar) Dawson L. Harber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1946 at 2:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19, 1946 to Oct. 23, 1946 and that I last saw him alive on October 23, 1946

Immediate cause of death	DURATION
Uremia	Unknown
Caused by:	
Due to Benign Prostatic Hypertrophy	"
Duration: Unknown	
Due to	
Other conditions Peri-rectal abscess	"

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underlioe the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul Padget
PAUL PADGET, M. D. ACT. CLIN. DIR.
Address V.A. Ft. Howard, Md. Date signed 10-23-46

RSE

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09820

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since July 1, 1946
Hospital, institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since July 1, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1916 Vermont Ave (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Reuben S Tucker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Florence M Tucker
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): December 22, 1876

8. AGE: Years: 69 Months: 10 Days: 2 If less than one day: ____ hrs. ____ min.

9. Birthplace: Howard County Md (Town, county, and state)
10. Usual occupation: Mixer Cutter
11. Industry or business: Confectionery
FATHER 12. Name: Guy Tucker
FATHER 13. Birthplace: Howard County Md
MOTHER 14. Maiden name: Sarah Wheeler
MOTHER 15. Birthplace: Howard County Md
16. Informant: Personal History- Hospital Records
Address: Eudowood Sanatorium, Towson 4, Md.
17. Burial, cremation, or removal. Which? Buried Date thereof: Oct 27 1946 (month) (day) (year)
Cemetery or crematory: Good Shepard
Location: Rockland Howard Co Md
18. Funeral director: Robt Carl B. M. Walters
Address: Platt & Stricker Sts
19. Oct 25 1946 (Date rec'd by registrar) A. W. Hedrick Registrar

1-25-46-10

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24 1946 at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946 to October 24 1946 and that I last saw him alive on October 24 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	
Due to:	17 Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work?

23. SIGNATURE: W A Bridges M. D. or other
Address: Towson 4, Maryland Date signed: 10-24-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

CERTIFICATE OF DEATH

09821

Reg. Diat. No. 40

1. PLACE OF DEATH:

County Balto.

City or town Fullerton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 53 yrs.

Hospital, Institution, or street address where death occurred:

Vollmert Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto

City or town Fullerton Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. Vollmert Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Berthold C. Vollmert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Amelia Vollmert

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11/15/66

8. AGE: Years	Months	Days	If less than one day
79	10	25	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Truck farmer

11. Industry or business farming

FATHER

12. Name Geo. Vollmert

13. Birthplace Germany

MOTHER

14. Maiden name — —

15. Birthplace Germany

16. Informant Mrs. B. C. Vollmert

Address Vollmert Ave. Fullerton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 13 46 (month) (day) (year)

Cemetery or crematory St. Michaels Luth. Cem.

Location Balto. Co. Md.

18. Funeral director Lauralen Funeral Home

Address 7401 Belair Rd.

19. 10/11/46 (Date rec'd by registrar) W. M. Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10th. 1946, at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1945, to Oct 1946

and that I last saw him alive on Oct 8 1946

Immediate cause of death	DURATION
My cardial insufficiency	12 hr.
Due to Cardio Vascular Disease	many years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

** SIGNATURE G. L. Wilkinson M.D. M. D. or other

Address 5713 Belair Rd Date signed 10-11-46

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09822

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, institution, or street address where death occurred:
Ebenezer Road & Eastern Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Ebenezer Rd. & Eastern Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Benjamin C. Ward.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Margaret Oates Ward

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 24, 1903

8. AGE: Years	Months	Days	If less than one day
43	5	29	..... hrs. ..... min.

9. Birthplace: Michigan
(Town, county, and state)

10. Usual occupation: Store Keeper

11. Industry or business

FATHER — 12. Name: William Ward

13. Birthplace: Michigan

MOTHER — 14. Maiden name: Elizabeth Black

15. Birthplace: Michigan

16. Informant: Mrs. B. C. Ward

Address: Ebenezer Rd., Chase, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 26, 1946 (month) (day) (year)

Cemetery or crematory: Lakeside Cemetery

Location: Port Huron, Michigan

18. Funeral director: Lasanka Funeral Home

Address: 7401 Belair Road

19. Oct. 23 1946 (Date rec'd by registrar) John S. Cornely Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23rd 1946, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1942 1946 to Oct 23 1946

and that I last saw h... alive on Oct 21 1946

Immediate cause of death	DURATION
Tertiary Syphilis	4yrs.
Due to	
Due to	
Other conditions: Diabetes Mellitus	10yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John C Baier MD
M. D. or other

Address: 815 Eastern Ave. Date signed: 10-23-46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 08822 44

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, Institution, or street address where death occurred:
Veterans Adm. Hospital, Fort Howard, Md
How long in hospital or institution? 19 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: Baltimore
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No.: 1925 Orleans Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WWtwo

3. (a) FULL NAME: WEIDNER, James C

3. (b) Social Security Number: 215-09-1770

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Margaret Weidner
6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): 27, Dec, 1916

8. AGE: Years	Months	Days	If less than one day
29	9	23	..... hrs. ..... min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business:

MOTHER FATHER
12. Name: Robert Weidner
13. Birthplace: Baltimore Maryland
14. Maiden name: Stella Ball
15. Birthplace: Baltimore Maryland

16. Informant: Clinical Records Veterans Adm.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-24-46 (month) (day) (year)
Cemetery or crematory: National Cemetery
Location: Baltimore, Maryland

18. Funeral director: John Miller
Address: 2334 Jefferson Street Balto, Md

19. 10/21/46 (Date rec'd by registrar) 19..... A. W. Bedner Registrar
1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20, October 1946, at 12:15PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1, October, 1946 to 20, October 1946
and that I last saw him alive on 20, October, 1946

	DURATION
Immediate cause of death: Carcinoma of Testicle, Rt. with generalizied metastases	Unknown
Due to:	
Due to:	
Other conditions: Hypertension arterial	Unknown

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
Robert M Cullison, M.D. Clin Dir. M.D. or Coroner
Address: Fort Howard, Maryland Date signed:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

09824

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Balto.
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 2506 Parkview Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto.
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2506 Parkview Drive
(If rural, give LOCATION)
2.(a) If veteran, name war: W. W. #1

3.(a) FULL NAME: Clarence Edgar Whitmore

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife: Grace Lenore Whitmore
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): Sept 29th 1901

8. AGE: Years	Months	Days	If less than one day
45	0	5	...hrs. ...min.

8. Birthplace: Union Bridge Md.
(Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: Building Specialties

FATHER
12. Name: ~~Whitmore~~
13. Birthplace: John Whitmore Pa

MOTHER
14. Maiden name: Emma McKinney
15. Birthplace: Pa

16. Informant: Frank C. Whitmore
Address: 4505 Prospect Circle

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/7/46 (month) (day) (year)
Cemetery or crematory: U.S. National
Location: Balto. Md.

18. Funeral director: William Cook Inc
Address: 1217 St. Paul St. Balto. Md.

19. 10/7/46 (Date rec'd by registrar) 19... A.W. Hedrick Registrar

MEDICAL CERTIFICATION

1255

20. DATE OF DEATH: Oct 4th 1946, at Home

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 13th 1945, to ... 19...
and that I last saw h.i.m. alive on Jan - 23rd 1945

Immediate cause of death	DURATION
1) Lymphosarcoma	- 18 months
Due to	
Due to	
Other conditions - Secondary - Anemia	

(Include pregnancy within 3 months of death)

Major findings of operations: - Biopsy of Glands - showed Lymphosarcoma - Date of op. -
Autopsy results: - None -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Earl L. Chambers M.D.
M. D. or other
Address: 4108 Liberty Hts. Date signed 10/5/46
Howard A. Andrews M.D.

1-35

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

09825

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural - Baltimore Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
7219 Hilltop Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Rural - Baltimore Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7219 Hilltop Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Windish

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Joseph Windish

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 8, 1873

8. AGE:

Years	Months	Days	If less than one day
73	1	21	..... hrs. ..... min.

9. Birthplace: Hungary
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Stephen Meilinger
13. Birthplace: Hungary

MOTHER
14. Maiden name: Teresa Unknown
15. Birthplace: Hungary

16. Informant: Elizabeth Windish
Address: 7219 Hilltop Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2 1946 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Belair Road

18. Funeral director: Wm. Cook Inc.

Address: 1217 St. Paul St.

19. 10-30 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 29 1946, at 3 05 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 29 1946 to Oct 29 1946

and that I last saw her alive on Oct 29 1946

Immediate cause of death: Uremia

Due to: Chronic nephritis

Due to: Cardio-vascular-renal Hypertension

Due to: arteriosclerosis

DURATION
Oct 27 1946

Other conditions: Cerebral Hemorrhage Oct 29 1946

Pt. Side - Hemoplegia -
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Louis F. Krumrein M. D. or other

Address: 722 N. Kenwood Ave Date signed: Oct 30/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

09827 P

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Baltimore Highlands
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Baltimore Highlands
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3009 Illinois Ave
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Margaret L. Wockenfuss

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Earl Wockenfuss
6.(c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) Jan 15th 1885

8. AGE: Years	Months	Days	If less than one day
61	8	24	.....hrs. .....min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name George Hunsperger
13. Birthplace Md.
MOTHER 14. Maiden name Emilia Miller
15. Birthplace Md.
16. Informant Earl Wockenfuss
Address 3009 Illinois Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 11th 1946 (month) (day) (year)
Cemetery or crematory St. Paul's Cem?
Location Westminster Baltimore Md.
18. Funeral director Dill Bros.
Address 3109 Frederick Ave
19. 10/10/46 19.... A. H. Fedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 19 46, at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 19 46, to Oct 3, 19 46
and that I last saw h. alive on ..... 18....

Immediate cause of death	DURATION
Carcinoma of Stmach	6 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
.....Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Paul Schofield MD
M. D. or other
Address Box, Ampalett Date signed 10/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

09826

Reg. Dist. No. 30 1

8

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years, 3 months, 4 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 9 yrs., 3 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2042 Fountain Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Felix Wodarczyk (Wlodarczyk)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
60	?	?	..... hrs. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Stevedore

FATHER 12. Name Volcher Wodarczyk

13. Birthplace Poland

MOTHER 14. Maiden name Susana Korkansky

15. Birthplace Poland

16. Informant Hospital records

Address Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-12-46 (month) (day) (year)

Cemetery or crematory Holy Rosary Cem.

Location Balto. County

16. Funeral director John M. Welch

Address 401 S. Chester Street

19. 10/11/46 (Date rec'd by registrar) A. W. Hedrick Registrar

I-35

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1946, at 10:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1937, to October 10 1946 and that I last saw him alive on October 10 1946

Immediate cause of death	DURATION
Chronic myocarditis	over 8 months
Due to Chronic interstitial nephritis	-indef.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Fuerk, M.D. M. D. or other

Address Catonsville-28, Md. Date signed 10-10-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

P

P 09828

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1805 W. Pratt St.
(If rural, give LOCATION)
2.(a) If veteran, name war WWI

3.(a) FULL NAME Benjamin G. Young

3.(b) Social Security Number Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married- Separated

6.(b) Name of husband or wife Grace T. Young
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 23, 1881

8. AGE:	Years	Months	Days	If less than one day
	65	4	20	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Unemployed
11. Industry or business
FATHER 12. Name John A. Young
13. Birthplace Baltimore, Maryland
MOTHER 14. Maiden name Lena Geer
15. Birthplace Baltimore, Maryland
16. Informant Clinical Records.
Address Fort Howard, Maryland
17. Burial Date thereof Oct 17-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory National Cemetery - Balto Md
Location Baltimore
Funeral Director Potter & B.M. Walter
18. Funeral director Walter's Funeral Home
Address Pratt & Stricker Streets, Balto., Md.
19 10/16 19 46 A W Hedrick DR
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13th 19 46 at 11:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 28th 1946 to October 13th 19 46
and that I last saw him alive on ..... 19 .....

Immediate cause of death	DURATION
Uremia	11 days
Terminal pneumonia; bronchial. Elapsed days.	
Due to	
Due to Chronic interstitial nephritis. Duration: Not stated.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE L. James Thomson Jr. M. D. or other
Address Fort Howard, Md. Date signed 10/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M